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their application in
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and
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their application in
PUBLIC HEALTH
SOCIAL WORK

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with supplementary chapters in public health social work

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FOREWORD

All the helping professions practice consultation and are concerned with its improvement. All these professions are concerned with mental health concepts as they can be used to make consultation more meaningful. Although the focus of this publication is on concepts of mental health and consultation, particularly in their application to public health social work, it carries implications for consultants in many fields.

This publication, *Concepts of Mental Health and Consultation*, brings together papers presented at two institutes sponsored by the Medical Social Work Education Project in Public Health held at the University of California in Berkeley in the summers of 1955 and 1957.

The institutes themselves were a cooperative endeavor of the Schools of Social Welfare and Public Health at the University of California and the California Department of Public Health. Financial support came from a grant by the Children's Bureau.

Dr. Gerald Caplan, Associate Professor of Mental Health, Harvard School of Public Health, led both institutes. He presented the material which forms the major portion of this book, *Mental Health Aspects of Social Work in Public Health*, at the first institute. At the second institute in 1957, he presented a paper embodying his later ideas on the subject of consultation entitled "Mental Health Consultation" and this is included in the present volume. Miss Virginia Insley, Chief, Medical Social Work Section, Division of Health Services, Children's Bureau, served as co-leader of the second institute and presented a paper on "Social Work Consultation in Public Health." Another paper by Miss Insley, "Program Consultation in Public Health Social Work," was made available to the members of this institute and is included here because it fills out the picture of the social work aspects of this topic.

Those who were invited to attend these two institutes included all the social workers employed in public health departments in the Western region; the social work interns in public health at the University of California, School of Social Welfare; and a few medical social workers interested in services to mothers and children.

The papers presented at these institutes proved to be so valuable and unique that the members were agreed that they should be made available to a wide audience of people in public health and social welfare and most particularly to public health social workers. With the publication of this volume, the content of these institutes becomes available on a national basis to both education and practice in public health.

The University of California to this end generously granted the Bureau permission to bring the material together in this volume. To the university and to the members of the committee who planned these institutes, the Children's Bureau is grateful.

Katherine B. Oettinger

KATHERINE B. OETTINGER,
Chief, Children's Bureau.

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INTRODUCTION

During the years since the passage of the Social Security Act in 1935, the demand for medical social workers in public health programs directed towards the preservation and improvement of public health and the prevention of illness and physical handicap has steadily increased.

As programs got underway, funds made available to States under this Act and administered by the Children's Bureau of the U. S. Department of Health, Education, and Welfare, made it possible for State and Territorial departments of public health to establish social work positions. The need for more adequate health services at the local level soon became apparent and the demand for medical social workers increased as public health departments developed and extended their programs.

The question of how to meet the demand for professionally trained social workers is of great concern to the social work profession. The public health field poses a particular dilemma. Social workers in this field require professional sureness and skill gained through practice under supervision following completion of the two-year graduate course in a school of social work.

The social worker in a public health program in some instances works directly with individuals, groups, and communities. But many social workers in these programs employ their professional knowledge and skill through the method of consultation to members of other professional disciplines, who themselves are in a helping relationship to people.

The Children's Bureau has contributed to the recruitment of qualified personnel by making funds available through State departments of public health to some schools of social work located in different regions of the country to prepare social workers for practice in the field of public health.

The medical social work education project in public health at the School of Social Welfare, University of California, Berkeley, is one of these educational programs. With a portion of the Children's Bureau grant, the project sponsors an annual institute for social workers employed in public health settings in the Western States, Alaska, and Hawaii. In this way, the project takes some

responsibility for improvement of practice in public health by bringing together social workers already employed in the field for discussion of theoretical concepts, common problems, and ways of meeting these problems.

The Institutes on which this publication is based were the first and third annual institutes under the auspices of the project. In 1955 the Institute on Mental Health Aspects of Social Work in Public Health devoted considerable time to a discussion of consultation. Because of the increasing need for social work consultation in relation to child health conferences, prenatal clinics, and parents' groups the institute focused on: (1) Presentation of theoretical content essential to an understanding of maternal and child health; and (2) the social worker's application of this knowledge through the method of consultation. Because so many workers wanted to know more about the application of the specialized techniques described by Dr. Caplan to the job of the public health social worker, the 1957 Institute placed more emphasis on the social worker's responsibilities in public health. Since the 1955 and 1957 Institutes represented a continuing consideration of the process of consultation, the two Institutes have been combined into this publication.

The proceedings of the 1955 Institute based on a transcription of the Institute were originally published in 1956 by the University of California Press under the heading "Mental Health Aspects of Social Work in Public Health." This volume has been completely revised and is included as the first section of the present volume.

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MENTAL HEALTH ASPECTS OF SOCIAL WORK IN PUBLIC HEALTH

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CHAPTER I

An Overview

In planning for this institute, the committee believed that, on the whole, those attending would be most interested in the application of mental health principles to public health social work, and that therefore we ought to spend some time talking about techniques, about how basic material might be made use of in everyday work. But when we asked ourselves how to present this in an institute, we could not see where to begin.

Obviously, we should have some discussion of modern ideas on mental health. But how much? Many days could be spent on personality development or the mother-child relationship. This is a new area and probably will always be a new area. That is, we are always making new advances here because we are so ignorant in this field.

Take, for instance, a simple thing like the emotional implications of pregnancy. We know almost nothing about this, although we talk about it glibly enough. A review of the literature shows there has not been a single, respectable piece of research work on the emotional life of a pregnant woman and how this affects the mother-child relationship. This is one area where we could talk for a very long time. The question was, how much time should we give to such material?

We finally arrived at a plan, according to which I will first give you a broad overview of the subject. I shall do a fair amount of talking about personality, the ingredients of personality and personality development, the way in which the individual personality interacts with the field of forces in the family circle, concepts of crises, concepts of equilibrium, of mental health, and epidemiological ideas in regard to mental health and mental ill-health. After this, I will discuss one specific area of the field; namely, the emotional life of a pregnant woman and how that later develops into the mother-child relationship. I will take the mother-child relationship and the emotional development of the child through the first year. In passing, we may be able to touch on mother-child separation and deprivation, and perhaps the implications of congenital anomalies.

The material I have just described is related primarily to the psychology of children and mothers and families. But all of us were once children and when we talk about the personality development of children we are also talking about the personality development of nurses and social workers and child-care workers generally. That is, the topics we are going to discuss are not applicable only to the behavior of clients; they also have applications to our own behavior and the behavior of the people with whom we deal in our professional lives.

I should also like to present to you some details of the mental health consultation technique which we have worked out in Boston. This is a special type of consultation. I should like to describe in some detail the conceptual framework and the techniques involved in this kind of procedure. It is a procedure whereby a consultant helps a consultee. By consultee we mean a care-taking agent of the community, such as a social worker, a pediatrician, a nurse, a child-care worker, anyone who deals with people when they are in trouble as an agent of the community whose job it is to take care of them.

When the trouble has emotional implications, which it very often does, the care-taking agent may get into difficulties. I will present a technique which has been worked out to help the care-taking agent deal with the mental health problems of his clients as part and parcel of his everyday work. In other words, I will describe a technique designed to help a nurse, for example, do a more competent job as a nurse in dealing with the emotional implications of her patients. It is not a technique to teach a nurse casework or psychotherapy or anything like that.

When I take up this subject I should like to begin with a discussion of consultation in general, of how our technique in consultation resembles and differs from techniques which other people may have been using for years. People have been providing consultation for a long time without giving too much thought to exactly what it is they do. Many people, especially those who are gifted in their basic personalities, are doing a very good job in many cases. But the whole subject is a bit hazy from the point of view of system. People do not know why they sometimes succeed in something and sometimes fail; they do not know why one person sometimes succeeds and another person fails.

This field of consultation seems to be at about the stage that casework was when it began to be differentiated as a specific discipline. Social workers had been helping people for years. They had done a very good job in some cases and had failed in others. But they did not know why they sometimes succeeded and sometimes failed. Therefore people began to tease apart their ideas of

what they were doing and to systematize them. I think we may have reached that stage now in regard to consultation.

It is important, from the mental health point of view, to realize that the public has lately become very interested in "community mental health." All over the country there is a tremendously increasing interest in spreading community health services, and the money is being provided.

But when you ask what we should do with this money, you get a very blank answer. We have begun to realize that we cannot keep on opening more and more therapeutic clinics, and are beginning to talk in terms of the prevention of emotional ill health. This is fine, so far as it goes, but when we come to filling in details we find that we do not have much information. But it seems clear that consultation services may give us an important answer.

Community organization is another big area where a great deal of work needs to be done. Actually, you cannot separate consultation with an individual in an agency from a certain interest and a certain knowledge and a certain sensitivity relating to the community in which you find that individual. This may be the smaller community of the agency, or it may be the larger community which surrounds the agency. In either case, you never deal with just the individual. In fact, I would say that the primary emphasis of preventive psychiatry at the present time is on seeing the individual as part of a field of forces. If you are considering helping an individual by means of consultation to take care of his clients, you must also consider the community structure in which he works. You must know something about the community which surrounds the individual care-taking agent and which impinges not only upon him but also upon the client.

I want to be certain that you all know what I mean by the words "care-taking agent" and "client." By the "client" I mean the member of the community who is in difficulty, and by "care-taking agent" I mean the person whom the community provides to help that person. These are useful concepts that you can generalize from. You can talk about care-taking agents and refer not only to nurses and social workers, but to pediatricians, obstetricians, general practitioners, policemen, clergymen, who are very important, foster mothers, and so on. Foremen in factories may also be care-taking agents, as may any key people, who are occupying certain roles or fulfilling certain functions in the community which the community lays upon them. This role makes them important people for a relatively large number of other people who are to some extent dependent upon them, especially when they are in trouble. When

such people are in trouble, society sends in these care-taking agents to help them.

Now there are different levels of care-taking agents. People who give the kind of consultation we are talking about are care-taking agents who deal with other care-taking agents. Doubtless, those people have some contact with clients, but mainly they deal with other agents. This gives us a pyramidal system of organization, with the more highly trained people on the higher levels. Each person deals with a number of people who are down lower in the hierarchy, in the sense of being less well trained, and these in turn deal with a number still lower down in terms of technical training.

Such an organization offers great hope for a broad preventive program. By pyramiding in this way, you can deploy your highly trained workers in such a way that you will need fewer and fewer of them. This is the reverse of the situation in therapeutic programs where the people who are actually in contact with the client must be specialists, for example, in psychotherapy or psychiatry. Here the person dealing with the patient, such as the psychotherapist, has to be very highly trained. As a matter of fact, we are beginning to change this situation even in the field of therapy. We have learned, for instance, that even in a hospital setting we can do quite a bit of therapeutic work merely by altering the therapeutic milieu. We are now using relatively untrained people in mental hospitals; that is, the people who have real contact with the patient are untrained, temporary workers, the aides.

I strongly recommend that you read a book by Stanton and Schwartz, called *Mental Hospital*.¹ This is a social and psychiatric analysis of a disturbed ward in a small, private mental hospital in Washington, D. C. Certain principles are developed in that book which I also have come to, by a completely different route. In the hospital described in this book the people in contact with the patient are the aides. These people are amateurs, almost completely untrained workers, who remain in the hospital on the average for 2 to 3 months and then leave. Yet it is upon their backs that the major responsibility for actually caring for the patient rests.

Apart from these experiments, however, in the therapeutic field the highly trained person is at the grass roots level. But a community health program is likely to make a different approach. Perhaps one of the major contributions to preventive medicine has been the methods developed by public health workers whereby relatively untrained people carry on the actual operations in the field, and the more highly trained are placed further and further up in the

¹ Alfred H. Stanton, Morris S. Schwartz: *The Mental Hospital*. A study of institutional treatment in psychiatric illness and treatment. New York: Basic Books, 1954. 492 pp.

pyramid. This allows some possibility of community coverage, which is the thing we must aim for nowadays, at least in our planning.

In what follows, I will doubtless cover ground which most of you know a lot about, but I hope that I will cover it in such a way that you will get a new perspective on it. The effect of maternal deprivation and mother-child separation is a subject which is very close to my heart, and I am going to discuss it, even though I know that it is familiar to many of you. You all know about personality development, I am sure, but I will talk about this too, from the point of view of my own work.

It is important to remember that whether we go from the particular to the general, from mother-child relationship and pregnancy to personality development, or move in the other way, it makes little difference since everything is linked with everything else. It does not matter which way we move as long as we realize we are dealing with a circular system, that all these things are integrally linked together, that we separate them out only to talk about them systematically. There is nothing that comes first, as it were, neither the chicken nor the egg!

CHAPTER II

Ingredients of Personality and Personality Development

I am going to open my remarks with a few words about personality. I think we should start by pretending we all know very little and seeing whether we cannot build up something in the way of first principles. So I am not going to apologize for talking about things you already know.

First, we must realize that the concept of personality is simply a framework for analyzing the behavior of a person, in order to predict his actions and in order to understand the connection between his actions and the situation in which we see him. In dealing with people we would like to know ahead of time what we can expect them to do and how likely they are to come up to our expectations. In order to do that we have to know certain things. We have to know certain things about people in general and certain things about the particular person. Of course, the more we know about him the more likely we are to be accurate in our predictions. It would be nice, for instance, to know what has happened to him in the past and how he has reacted in the past. We may not be able to get such information, but we can watch him in the present, and from the way in which he reacts to certain things in the present we can predict how he is likely to react to certain things in the future.

I suppose in our everyday work the most important characteristic which we ought to develop is sensitivity to the microscopic, to the tiny cues in the behavior of people that we are dealing with. We watch how certain things impinge upon them; we watch the little movements of the body, facial expressions, tone of voice, and so on, and from this we build up a picture of what this person is like. We build up such a picture in order to understand the present, and also in order to predict the future. In doing this we must remember that we do not know what stimuli are impinging upon the person. We cannot analyze a person in the same way that we can analyze a mechanical situation.

If you have a bridge and want to put a weight on it, you can take that weight and weigh it and learn objectively and accurately what it weighs. Then you can put it on the bridge and observe the strain response to a known stress. But you cannot follow this model very far in regard to human beings, because your conception of the forces impinging upon a person is not the same as his perception of them. And the effect of the forces impinging upon him will be due only partially to the objectively assessed forces, and much more to how he perceives, to the meaning he reads into the situation.

You have to realize that a person's perception of the reality of a situation is very much colored by what has happened to him in the past, and by his intrapsychic mechanisms, especially by certain emotional factors. So, when you are dealing with a person you must try and find out how he perceives the situation he is in. You must not jump to the conclusion that what you perceive will be the same as what he perceives.

You must also know something about his motivations. What does he want, and what are his goals? What are his values? I think we know something nowadays, at least a little, about how people develop motivations and goals.

Ingredients of Personality

What are the ingredients which can be said to make up a man's personality? I think the first thing that we must mention is the constitutional element. Maybe you think it is a bit strange that a dynamic psychiatrist should mention this first, but there are certain constitutional factors which are important. These are the limiting or enabling factors. You cannot predict a man's actions just from knowing his constitutional make-up, but knowing something about his constitutional make-up, you can predict the limits within which he is going to act, and the general way in which he may act.

Constitutional factors

For years people have talked about temperament; they have talked about reaction types. And what they say may apply even to the fetus.

For instance, a man called Sontag, in Yellow Springs, Ohio, has done a good deal of research over a period of years on the reaction types of fetuses. He has discovered that some fetuses are much more active than others. He has worked out little tricks he plays on the fetuses. He makes a loud noise near the woman's abdomen and sees how the fetus jumps. The fetus can hear at a certain stage

of its development. Sontag has a large tuning fork which he bangs, and the fetus reacts to this not only by movement but by changes in its heart beat. He has shown that there is a certain consistency about this. Some fetuses are consistently more quick on the uptake than others. Some fetuses' hearts beat much quicker as a result of these stimulations than others. And he has shown a certain correlation, although that part of his work is not too certain, between the activity of the fetus and the activity of the child after birth.

He has published a bit of work, that relates however to only seven cases, in which he has shown that the emotional state of the woman during pregnancy has an effect on the activity type of the fetus. These seven cases were all women who were extremely emotionally disturbed during pregnancy, and who had very active fetuses. These became long, thin babies who suffered from colic and had autonomic instability. From this Sontag deduces that there is a hormonal or some other direct connection between the emotional state of the woman during pregnancy and the activity and neuropsychiatric make-up of the fetus, the neuromuscular make-up anyway. Modern science is now coming around to showing that some of the old wives tales that we all thought were just superstition and nonsense may have something in them after all.

Incidentally, old wives tales usually do have something in them. This may not be what is on the surface, but if you distill them you will usually find some rather important wisdom, since these tales incorporate the wisdom of the people over the ages.

Others also have talked about the activity of new-born babies. Babies differ from one another when they are born. If any of you have worked for any time in a new-born nursery, you know this. There are certain, probably neurological, differences.

Margaret Fries in New York has been writing about this for years. She divides babies into the active ones, the inactive ones, and a middle group.

She drops a weight next to a baby and sees how soon the new-born reacts to this. She measures the reaction time and also the amount the baby jumps. She finds that some new-born babies consistently jump quicker and more, and others jump slower and less. She has followed this through and found that this thread can be recognized subsequently in the personality make-up of the child as it continues to develop.

Harold Stuart in Harvard has done research over the past 20 years or so in growth and development. He has shown that there are individual differences discernable all the way through, which are mirrored not only in emotional development but also in physical development or, as he would put it, not only in physical develop-

ment but also in emotional development. He got into this from the physical side, but he realized that the psychological development had to be taken into account too.

Over the years, there have been a number of psychiatrists who have talked about body build and personality type. You recall the work of Kretschmer, those long, thin people who developed schizophrenia when they became psychotic and the short, fat people who developed manic-depressive psychoses; the long, thin ones being introverted and the short, fat ones, extroverted, and so on. There is something in all this. Most of the people who work in this field carry this idea to an extreme degree and work it out in much more detail than perhaps the facts warrant.

So there are these constitutional differences, and they are repeated in other aspects of the personality. That is, people have different strengths in regard to their instinctual drives and in regard to their appetites. Some people are constitutionally more aggressive, and others are not so aggressive. Some have constitutionally stronger sexual drives than others. Some have stronger hunger drives than others, and so on.

Not only does this side of the question vary, but the other side varies, too. That is, in mastering these drives, in dealing with them, people seem by inherent make-up to have different strengths, different abilities you might say, and these affect the methods they will use. There are people who will deal with a need or a stress situation by fighting. And there are others who will deal with it by turning away. I do not want to go into this too much because I do not think it is terribly important here, from a practical point of view. I only want to point out that there are the active people and the passive people, that this difference can be traced, maybe from the stage of the fetus, and certainly from the stage of the new-born.

But I must warn you here that these constitutional differences are very much overlaid with acquired characteristics and culturally determined modes of behavior.

Cultural factors

There are cultures which deal with problems by passivity, and there are others which deal with problems by activity. Let us take one example.

A few weeks ago, I was consulted about the family of a child with sickle-cell anemia, with alleged hopeless prognosis. The family were Italian Catholics. Their reaction to the fact that their child was going to die was one of complete passivity and resignation.

They saw no reason why they should take him to doctors when he was going to die any way.

The reaction of the medical people, on the other hand, was one of extreme activity. The culture of the physicians, in a situation like that, is, "Here we are, faced with a child who is going to die. We have to do something, and have to keep at it."

As a matter of fact, that attitude seems to have had some effect because the child, when we talked about him, was 17 years old and should have been dead a long time ago. But there was a constant struggle between the family on the one hand and the physicians on the other; the relatives wanting their child to be left in peace to die and the physicians saying they were not going to allow such a thing to happen.

So you must be very careful, in dealing with anyone, other than a new-born baby, in ascribing what appear to be basic elements in their reactions to their constitution. These may belong to the culture.

Intelligence

Among the basic elements, however, that we have to take into account is the element of intelligence. Maybe people are born with different degrees of intelligence. But the I. Q. does not mean nearly so much as we once thought it did. We now realize that what you measure in young children as intelligence is quite different from what you measure in adults. We have begun to realize that a good deal of what we used to think of as the intelligence level is not the constitutional innate capacity at all, but something which is compounded (as everything is compounded once you get beyond the first few days of life and maybe even then) or a mixture of these constitutional elements and life experience.

Intelligence, for instance, expressed as the intellectual level of the person, is very much influenced by a complicated set of emotional mechanisms. This was very well brought out in a meeting I attended in Copenhagen last year, in which child psychiatrists coming from all over the world, agreed that many children alleged to be mentally defective on the basis of a constitutional lack of intelligence are no such thing. That is, the picture which we recognize as that of a mentally deficient child is produced, in many cases, by emotional conflicts. In fact, there is a large group, which you will find in every colony of mentally defective individuals, who look mentally defective and who are not. They have normal or higher than normal intelligence, but they also have extreme disorders in their

emotional life which prevent them from deploying the constitutional ability which they have. These are the psychotic children.

But even disregarding the psychotics, there are many children who have emotional conflicts which interfere with the general deployment of their intellectual faculties. Certain differences in school which appear to be differences due to dullness are nothing of the sort, but are due to certain emotional conflicts which are linked to problems the child has had in his personality development. I am going to talk about this in a few minutes.

Instincts and drives

I think at this stage I ought to say a little about instincts and drives. This is one of the contributions of psychoanalysis to the theory of personality development. Psychoanalysis is a biological theory of personality development. Freud pointed out or hypothesized, of course this was only a hypothesis, that the origin of mental activity is in bodily functions and bodily needs, and that these are the source of the energy which drives mental mechanisms. He divided these mechanisms into two main classes, the drives of sex and the drives of aggression. Other people have divided them differently. It does not make much difference to us here how they are classified.

Nature and nurture

What does make a difference to us, and what we have to remember all the time, is that the growth and development of personality is determined by the unfolding of these instincts as the body grows and matures. These needs and these drives develop through various stages, which we probably will not have time to spell out at this institute but which have been spelled out. The personality is developed by the unfolding of these instincts and the control and the direction of their energy by the increasingly complicated mental organization of the individual. And this increasingly complicated mental organization develops in large part through environmental pressure.

What we recognize as the mechanism of the personality, among people brought up under ordinary circumstances, is a product of the constant interaction between these developing bodily forces, which have their mental content, and a very complicated series of interpersonal and social pressures. On the odd occasions when we find individuals who have grown up, as it were, in a social vacuum, like the famous wolf children abandoned by their parents in the woods and taken care of by animals (and there are a number of apparently

authentic accounts of such individuals), they do not seem like human beings at all, apart from their bodily shape. They do not have what we would call a personality.

You are all familiar, I am sure, with the work of Spitz, and the later work of Bowlby and Roudinesco. You have seen, or read, accounts of children brought up from birth in foundling homes or institutions where they did not have the kind of mothering which is normal and natural among human beings. They do not have the personality structure of ordinary people. They are not able to use their intelligence.

Of course, many of these children die at an early age. You remember Spitz' story² about his foundling home. There everything was so clean, the children were walled off in beautiful glass compartments so as not to have any cross infection, they were very carefully nursed, and a tremendous proportion of them died by the age of one from a wasting disease. He could not find out what it was. They just died. And those that do not die do not develop speech until much later than ordinary children. They do not develop a conscience like ordinary people. They do not develop the various facets of personality which we regard as usual in personality development.

This is not true only of human beings. Those of you who have not read Konrad Lorenz', *King Solomon's Ring*,³ should do so. It is not only instructive. It is a very exciting book, by an Austrian social biologist. He has shown that if you take a social animal, like a goose or a dog or a sheep, animals that don't live entirely on their own, and separate it at birth from other animals of its kind and from other animals generally, you get a distorted personality development, just as you do among human beings. So this type of personality which we see in human beings is not just a human characteristic. It is a biologically determined matter, and we have to think of it in terms of biosocial forces.

There is a difference, however, between man and these animals. The difference is in the length of childhood, or period of dependence. Most of these animals can fend for themselves a relatively short time after birth. Man can not. This long childhood, I think, accounts for the complexity of human personality. It is during this long period, when the young human is dependent and in close contact with older humans, that civilization is handed on. In the development of the personality this handing on of civilization continually gets mixed up with other elements that come from heredity.

² Rene A. Spitz: Hospitalism. Psychoanalytic study of the child. Vol. 1. New York: International University Press, 1945. (p. 53)

³ Konrad Z. Lorenz: *King Solomon's Ring*. New light on animal ways. Tran. by Marjorie Kerr Wilson. New York: Crowell, 1952. 202 pp.

It is interesting that in Hebrew, there is a word for the handing on of culture which is very similar to the word for the handing on of heredity. The difference is in just one letter. So we see that right back in the days of the Bible, people recognized the similarity. If we call the constitutional elements the "nature" of a person, and if we use the word "nurture" to express the factor of socialization, we would be close to the Hebrew way of thinking about these two factors.

Personality Development

You must recognize what I call "interdigitation," a continual interdigitation, of nature and nurture. As the young person develops, at every stage of his development, the natural forces of the unfolding instincts come into contact with and are influenced by the social forces in his upbringing. He is continually having different needs, and he moves on to the next stage according to the way in which those needs have been responded to by the people around him at that time. In other words, he is moving forward in his personality development by a complicated series of steps and to every step there should be an appropriate response. The response that is given should be not too much or too little. There should not be too much burden or too little challenge.

The ego: functions and development

Here I must bring in one other concept that we refer to very frequently in these days. (Notice that we are talking about a concept, not an object. We must not let ourselves be misled into reifying an abstraction.) The ego is our name for the mental organization which controls the biological drives and employs their energy for the socialized activity of the person in relation to his environment. In other words, beginning with these inner drives and needs which have energy, little by little in the development of personality we get a more and more complex organization which controls these and uses their energy to drive the person in regard to his activities. And when we say "his activities," we mean his activities in relation to the people around him.

We can identify any number of functions of this mental organization. It is a matter of choice how many divisions you make, but it is a good idea to think in terms of functions as you deal with people. I have isolated four of these.

First there is *perception*. The ego is the part of the personality which perceives; that is, it is the part of the personality which is in contact with the outside world. Then there is *integration*. The

stimuli coming from the outside world, which are perceived, are colored by past experience and are integrated, or brought together, with the past and with plans for the future. The third function is *execution*. The ego is the part of the personality which controls motility, which controls the carrying out of plans which the individual may make in regard to his own needs and the demands that are put upon him by his environment. And finally there is the function of *object relationship*; that is to say, relationships with other people.

Now different people, as a result of this interdigitation, of the way in which the pattern is developed, of what they came into the world with and what happened to them in the world, have developed different abilities and strengths, different capacities in regard to these various functions.

This mental organization, which we call the ego, is associated with something else that is rather hard to tease out, namely an awareness of self. This is something that develops gradually, that is sometimes not developed in a person until quite a late age, if ever. Maybe the fetus *in utero* has some kind of psychological awareness. I do not know. But certainly at birth and during the first few months of life, whatever psychological awareness there is must be very hazy and very unlike the kind of awareness we as adults have of ourselves.

Here we have a paradox. The development of this awareness of self depends upon the development of an awareness of others. So far as we can make out, a baby develops an idea of itself as a person through developing an awareness that there is something other than itself in existence. This usually takes place around the child's experience with the nipple. It feels some need, then somehow there is some nice, warm, wet, sweet stuff in its mouth and it does not feel this need any more. And sometimes it feels the need and the nice stuff is missing and it feels more and more tense. And you can see a baby getting more and more frustrated, wiggling and screaming and thrashing about when this nice stuff is not there in its mouth. According to Anna Freud, who has done a great deal of research in this area, it is during this very early period that the baby gets the idea that there is something other than itself in the world, that sometimes something is in its mouth and sometimes it is not. That leads to the first glimmerings of awareness of other entities.

I say entities, but these are not entities in the sense in which we ordinarily use this word, because there is considerable evidence that during the first 4 or 5 months of a baby's life it cannot be aware of another person. It is aware of what Anna Freud calls

"part objects." That is to say, it is aware of light, of odors, of touch, of sounds, etc. But it only becomes able to integrate these into the concept of a single object, of a single person, at about 4 or 5 months of age. Before that it may recognize its mother, but not as a person. It recognizes the smell, maybe, of the mother, or the sound of the mother, or the feel of the mother. These fragmented bits of awareness gradually become integrated into an awareness of a person.

Through this recognition of the mother at 4 or 5 months of age, the baby begins to recognize itself as a person, because this awareness of self goes hand in hand with the recognition of the other. Moreover, and this is the most important point for us, the baby's confidence in itself is related to its emotional interchange with this other person and its confidence in the other person.

Starting from these first beginnings of little fragments which come together and get integrated, the ego develops through a rather complicated process that I am not going to do more than hint at now. I suppose that the most advanced work going on at the present time in psychology and psychoanalysis is in teasing out the very complicated stages of development of the ego from these hazy beginnings. The way to do this is to study people with breakdowns. There you see the parts in which the ego fails, and in this way get some idea of what these first nuclear patterns were like.

An important point for us here, is that the development of personality is dependent upon this interchange with other people and therefore dependent upon the integrity of the perceptual apparatus. If there is something wrong innately or as a result of disease with the baby's sense of smell, touch, sound, or sight, this development of the ego is going to be interfered with in a major way. You may get either a slowness of ego development or a defect in the ego structure.

Effect of congenital anomalies.—Recently, we have come to realize that many of the children in institutions for mental defectives look mentally defective, and have disordered personality development and disordered ego structure, because of some disorder of the perceptual apparatus, such as blindness or deafness. On the other hand, some children develop certain personalities because of especially acute perceptions. The child with very acute vision or hearing may develop in a certain direction because he is picking up his knowledge of the world around him through that channel.

It is a difficult diagnostic problem to determine whether a child with a hearing defect, for example, is mentally subnormal. But the most important question is: Is it reversible? Can you do something for this child which will allow him to develop normally?

One should always go on the assumption that if you put in enough work, and put it in in the right way, you are going to be able to change the mental functioning of that child to an amazing degree.

It may be that the child has a constitutionally low intelligence. It is very hard to differentiate such a child from the one who, because he did not hear other people, did not develop speech, and was not able to communicate, and so got left behind. A child that was left behind 4 or 5 years ago, has missed out on stages of development that should have taken place by now. So, at a certain stage, we many find that irreversible damage has been done. We do not know nearly enough about when this takes place.

In *Emotional Problems of Early Childhood*⁴ there is an account of a child of three or three and a half who seemed deaf and mentally defective. At about 2 months of age he was separated from his mother. After that, he was in a succession of some 14 institutions until he came to the one in which the investigation was made. The child seemed to be mentally defective and deaf. Yet there were certain discrepancies; he seemed to hear some people and not others.

The child had no relationships with other people at all and this appeared to be a completely irreversible state. Yet, when one person spent long periods holding him and stroking him and doing other things, trying to interject herself into his world, she was able little by little to build up a relationship. Through this relationship, she was then able to get the child to go back and begin again and develop as he would have developed, at say, 4 or 5 months of age.

This is a complicated process, but it happens often enough for us to realize that we have, in the past, been taken in, time after time, by the apparent defectiveness of a child which was only a pseudo defect.

On the other hand, if that child had been 15 or 16, assuming he could have lived until then, it would be hard to envisage this kind of treatment taking place. It is hard to think of taking a 15- or 16-year-old child in your arms and cuddling him and taking care of him as though he were a little baby. So there is probably some stage at which one has to say that the damage is irreversible. But we do not know enough yet to say when this occurs.

If you have a child who is really deaf and who really has a personality disorder, the only question is what or how much can you do about it. My feeling is that, if you are prepared to put in the time and have the skilled people to do it, you can usually produce a result much, much better from the point of view of improving the child's personality than you ever thought possible.

⁴ Gerald Caplan: *Emotional Problems of Early Childhood*. New York: Basic Books, 1955. 544 pp.

There are, of course, mentally defective children who have no apparent emotional difficulty and no sense deprivation. A few children of this kind, put into institutions where they were given therapy, have changed remarkably in a period of 6 months or so. In some cases, the child's I. Q. has risen, over a period of years, from 40 or 50 to 80 or 100. Our old ideas are changing. We are at the beginning of a new period, and we do not yet know quite what the limits are. In my opinion we get off on the wrong track with these children in the first few weeks of their life. That is the time when we ought to provide services for them and we do not have such services; at least, I am not aware of any services at that particular stage.

It is a very difficult thing for a family, particularly for a mother, to deal with a child who has a congenital anomaly or a birth injury. If she is left on her own she is very likely to develop a disturbed relationship with the child and so compound his difficulty. The child will then have the physical disability and also an unhealthy emotional environment in which to grow. These two interact with each other. For this reason, a lot of the difficulties of these children can be traced back to this very early period. This raises problems which are related to public health administration.

In Boston we are doing some research on the reaction of families to a congenital anomaly in a child. We have found it very, very difficult to get our cases. There is a law in Massachusetts to the effect that a hospital or a physician having anything to do with a deformed child must communicate with the State health department. The State health department has special clerks who keep a file on these reports. Yet if you ask them how many such children there are, they say, "We don't know. People are not informing us of these crippled children." Even when they are informed, the child is likely to be 6 months or a year old, or even older. Actually, all they do there is list the names in the file. No service is provided at this young age. Perhaps that is why people do not report more of them.

The human environment

In speaking about the child with a congenital anomaly, I said that the child might have the burden of the physical defect plus another burden, and mentioned the disturbed mother-child relationship as a burden. There are some rather basic things that we should consider here. We all take it for granted that a child needs a mother. I have already said it ought, at least, to have a nipple that comes into and goes out of its mouth. I think we ought to

ask ourselves: Why does a child need a mother? Let us not take these things for granted.

We must realize that the developing personality needs an appropriate human environment, just as the developing body needs an appropriate physical environment. And the interactive possibilities are as important for the one as different types of nutritional elements are for the other.

Here I would like to interject that a child not only needs a mother, but at a later stage he needs a father, and at a still later stage sibling figures, and finally other nonfamily adult figures. Personality development requires identification with family figures and other figures; the self develops chiefly as a result of interaction with other people.

Here again culture must be considered. The supply of environmental figures at any particular time must be related to the growing needs and capacities of the child, but it is also dependent upon cultural patterns, the kind of society the child will live in during his future life, and the kind of personality which is appropriate to this particular society. You have to be very, very careful (especially in a country like this where we have so many different cultures and subcultures and so many mixed ethnic backgrounds) how you assess the environment of any child. You must be sure that you are not making value judgments based upon your own culture. Be careful when you say, "this is right" and "this is wrong," "this is good" and "this is bad," "this is the way you should bring up a child."

We do not know how anyone *should* bring up a child! All we can say is that if you bring up a child this way you get this type of result, more or less. But we do not know even that definitely. It was the fad a few years ago to tell parents how they should bring up their children if they wanted them to be emotionally healthy. All I can say is, that if you do certain things vigorously enough, you are likely to get emotionally unhealthy children. It would be nice if we knew the details of personality development and how this links up with ways of bringing up children so that we could say that certain ways are good and certain ways are bad. But I can only say that our fashions in this respect have changed almost as rapidly as our fashions in the length of dresses and ladies' wear.

Basic needs

However, there are some basic things that we do know. We know a good deal about the needs of people, and we are talking at the moment of the needs of children. We know that there are certain things that every child needs. Our knowledge about this is

very similar to our knowledge about nutrition. We know there are certain nutriments that everyone needs. But we can not go on and say, "If you want to develop into an athlete you must eat this and this kind of food; and if you want to develop into an office worker, you must eat this and this kind." All we know is that if you do not eat certain things you will suffer from malnutrition. What are the personality needs that must be met if one is to develop properly?

Love and affection.—First, there is a need for something that we call love and affection. Can we describe this a little better? It means being accepted as a person regardless of one's actions. For the child, it means hearing the parent say: "No matter what you do, whether you are a good boy or a bad boy, whether you are effective or not, whether you are successful or not, I love you. You are my child. I accept you." There is a certain quality about this which we can only call warmth. I have tried my best to tease this idea apart a bit, but I still come back to this. When I say warmth and love and affection, you all know what I mean; and I do not know how to define it further.

Comfort comes into this, too. When the child falls or gets into trouble or cries, the mother comforts it. Usually some bodily communication takes place here.

This type of emotional nourishment helps the development of self-esteem and ego integration. We know that this is so, because when it is missing we get low self-esteem and poor ego integration.

Emotional support.—Next we have emotional support, given in relation to a task. The child, who does not yet know very much about the world is attempting various things, and the adult lends his knowledge and his support to the child, helping him to climb over various obstacles. In other words, this need is related to the child's dependency. He needs to depend upon the adult. He needs to have his weakness made stronger by the adult's strength.

This is a kind of teaching. The adult makes the child stronger by teaching him and by adding to his strength in such a way that when the adult is not there the child retains the support. We can think of teaching and education as being the adult's building into the child the adult's support so that when the mother, for example, is not actually present the child can rely upon her teaching, which is another way of relying on her support.

Freedom.—On the other hand, as soon as you speak of dependence, you also remember, I am sure, that the child needs freedom. He needs to develop independence. He needs to be able to stand on his own feet when the parent is not there, and he also needs to be allowed to stand on his own feet when the parent is there. Here we have one of the complicated problems in bringing up chil-

dren; namely, there has to be a very careful balance between emotional support on one side and freedom on the other, so that the child's dependency needs are satisfied and his independency needs are also satisfied. This balance will vary as the child grows older. The parent has to be sensitive to the child's needs at a particular time. The mother must be able to satisfy the child's need for dependence and also be aware of his need for independence. If you get too much on one side or too much on the other, you get into difficulties in regard to the child's personality development.

Control and gratification.—Another important balance which must be maintained is between the control and the gratification of the child's instinctual needs. I think from what I have already said that you realize that a person's ability to control and hold in check his instinctual wishes depends upon the development of the ego. The younger the child, the less this is developed. The older the child, the more it is developed, or so we hope. Normally, the older the person, the more able he is to control his instinctual needs and bring them into relation with the needs of society.

One of the roles of the nurturing adult is to lend the adult's controlling strength to the child, at the stage when the child cannot control himself. In other words, one of the duties of the parent is to control the child.

Some years ago it was widely believed that control led to repression and repression led to neuroses, and all neuroses were due to the fact that you controlled your children. Therefore, you had to allow your children to be free and gratify themselves. That produced the best batch of candidates for child guidance clinics we've ever seen. They came from the highly progressive groups, where the people had been sold the idea that you should not suppress your child. You should not repress him. This made the children very, very anxious, because a child needs to have control lent him by an adult. Because he cannot control himself, a child gets very frightened without this.

I remember a woman who brought her child to me when I was in London. She told me she was having trouble with the boy. She was well-off and had the boy in a very progressive school. Someone had advised her to take him out of there and put him in one of the ordinary grammar schools. She thought this was peculiar advice. But eventually she did make the change and was amazed.

When the child came home the first day, he said: "This is a marvelous school. There is a wall around the playground, and there are bars around the wall, and you cannot get out." This appealed to him because in his instinctual life he had cruel, aggressive fantasies which had been frightening him for years. No one was con-

trolling them. He was afraid he was going to destroy his mother and himself and the whole world. This is one of the things a parent should do for a child; namely, as long as the child cannot control his instincts, the parent should step in and control them for him.

On the other hand, a child needs a certain amount of gratification of his instinctual needs, and it is part of the role of the parent to provide certain gratifications. If you move over to the other extreme and cut off everything, never allowing the child to be aggressive at all, you produce a situation which is just as bad as the opposite one. That is, you may produce a situation where the child is forced to deny and suppress his bodily needs. This would mean that he moves that energy out of circulation, that the energy which comes from the instinct is driven back and pushed away. So if you get too much on the other side of the balance you also get distortion of personality.

If you keep a proper balance between gratification and control, you help the child to develop a tolerance for frustration. If he gets enough gratification he becomes willing, little by little, to postpone gratification.

I suppose you are all familiar with the situation of persons who have been starving for a long time and are suddenly faced with food. They simply grab it and push it into their mouths in a horrible way. They eat until they are bursting and then grab all the food they can and put it in their pockets. We saw this in people released from concentration camps. It is really a pathetic sight. But there is nothing special about these people. It would happen to any of us in those circumstances. These people cannot believe they can afford to postpone gratification, that there will be another meal next time. Those of us who normally have reasonably full stomachs are prepared to eat a certain amount and leave the rest; we know we can come back and have more later. This tolerance of frustration, this willingness to postpone gratification is one of the things an adequate balance between control and gratification develops in the child.

Healthy mother-child relationships

Now the question is, how does any mother ever manage to perform successfully this very difficult task? Love and affection and warmth and comfort, that is easy enough. But what about this complicated business of maintaining a balance between emotional support and freedom or independence, controlling his instinctual needs and at the same time giving him a certain amount

of gratification? To tease out these ideas is a very difficult job for a professor of psychiatry. The interesting thing is that an ordinary mother, with an ordinary relationship, does this automatically. What has taken us years to figure out is simply an analysis of an ordinary relationship of an ordinary mother with her child. The ordinary mother has innately the ability, probably biologically determined, to perceive the child's needs of the moment and to satisfy them in just the right kind of way. She is guided in this, insofar as she needs to be guided, by the traditions of her society, or culture. If she is in tune with her culture on the one hand and in tune with her child on the other, everything carries on and you get a healthy personality development, because you have a healthy mother-child relationship.

If, on the other hand, you get some disorganization of the culture or some tension between the woman and her culture, she may not know what to do. I suppose this is true in many parts of American culture today, since this country is a melting pot, where traditions have gone by the board and where there are likely to be tensions between younger people and their immigrant parents. In situations like those you get difficulties because the woman does not know what to do and starts reading books. This is a bad thing, because what the woman gets from books is a very limited set of traditions, and one she cannot be too sure about since of course there are other books. She may get another book and find it says different things. Then she is really lost.

It is possible to define a healthy mother-child relationship in such a way that we can recognize it. This is a very important definition. We have managed to tease it out through a good deal of experience in child guidance clinics. A healthy mother-child relationship is one in which the mother is primarily motivated in her handling of the child by her sensitivity to his needs and will attempt to satisfy them to his best advantage at that moment. We can contrast this with an unhealthy or disordered mother-child relationship in which the mother is oriented in her handling of the child primarily to satisfying her own needs. In other words, the undesirable, or unfortunate mother is the one who perceives first of all her own needs and uses the child to satisfy them, whereas the good mother, who thank goodness is in the vast majority, is the one who in dealing with the child is primarily sensitive to his needs.

This definition does not mention the intelligence of the mother, the culture of the mother, or what she does in satisfying her child's needs. What she does will be determined by her culture and background and surroundings. If the child has a need and the

mother has a need, and she turns first to the child's need, we have a healthy relationship.

Of course, a mother gets paid by her child for being sensitive to his needs. I suppose one of the signs of healthy motherhood is that the woman accepts this payment and believes that it is payment. A mother who is reacting primarily to the child's needs and satisfies or attempts to satisfy these needs gets paid, because she gets thanks from the child. The child develops, and she gets satisfaction. I suppose there is no more beautiful sight, really, than a nursing couple, as Middlemore has called them, a mother and a young infant, where the mother is satisfying the child's needs and is herself at the moment of suckling getting as much satisfaction as the child is getting in sucking. She is getting it in two ways. She is getting it, first of all, by the actual giving of milk. But also she is getting it because she identifies herself with the child and in a vicarious way receives the milk as well as gives it. If you watch a mother suckling a baby, you will see that the woman moves her lips as the baby sucks. And if you watch other adults watching this, you will see them also moving their lips. So the adults are also identifying themselves with the child and sucking at the same time.

I think it is obvious from what has been said so far that one important function of the ego is to master the internal and external environment. In other words, if a child wants to do something, he imagines it and builds up a fantasy. He daydreams it. If something is not to his liking, he masters it by some kind of imagination. This is a primitive type of thinking. We find this in certain primitive societies. In certain cultures, it is the dominant thinking of the culture.

We also find this in adults in our own culture at certain times. When problems of reality get too difficult, a person may regress into fantasy thinking. This same primitive method of thinking is found, for instance, in dreams. You also often find it where the ego breaks down, as in a psychosis.

Now the thing we have to realize is that a child, up to the age of, say, six or seven, does very little in the way of logical thinking in regard to his important problems. He spends a lot of time in fantasy. Piaget has spoken and written quite a lot about it, and considers the development of the sense of reality in the child as a measure of the development of the child's personality.

This fantasy thinking, this thinking which is not based upon strict regard for the actualities of reality, continues to a greater or lesser extent in all of us, in some areas of our thinking, throughout life. This brings me back to the subject of perception. You

remember I said that perception is based, on the one hand, on the stimuli coming in through the senses, but on the other hand on a coloring which comes from our internal mechanisms. That coloring is very often a manifestation of our fantasies, of our wishes, of our daydreams, and of all kinds of complicated emotionally toned, interrelated thoughts.

I suppose you could say that this is one measure of the mental health of a person. If you had to decide whether someone was mentally healthy or emotionally healthy or not, one measure you might use would be the degree to which he had attained this sense of reality, and the degree to which his perceptions were or were not colored by fantasies. To be sure, most of us, have our perceptions colored by our fantasies in some way.

We use the term task-oriented to indicate the type of perception which is colored least by fantasies, and self-oriented for the kind of perception which is very much colored in this way. If you will think back on my definition of a healthy mother-child relationship, you will see that the healthy mother-child relationship, in which the mother is motivated by her perception of the child's needs, is task-oriented. This mother is picking up the cues of the environment as they appear. On the other hand, the mother who has a disturbed relationship with her child is self-oriented. She sees the child through a filter as it were, and this filter is very much colored by her own needs at the moment.

Now an important function of education is to help the child develop a sense of reality. This must include not only an undistorted perception of the environment but also an undistorted perception of himself. I suppose one of the ways in which you would differentiate an emotionally healthy person from an emotionally unhealthy one, whether child or adult, would be the degree to which they are able to perceive themselves as they really are, or the degree to which they imagine themselves to be either better or worse than they really are. This involves not only their perceptions of themselves, but their perceptions of other people, and their ability to know what other people are thinking of them. The closer these perceptions are to objective reality, the less distorted by fantasy, the more emotionally healthy that person is, other things being equal.

Now I must speak briefly about defense mechanisms. I am sure the concept is familiar to everyone here. The techniques which the ego develops to harness the instincts are known as defense mechanisms. Now the characteristics of a personality, the ways in which one person differs from another and the ways in which you depict his behavior, depend on the types of defenses he

uses, the sorts of mental habits he has acquired to maintain a balance between his internal needs and the external demands of his environment. I think it is obvious that the methods of child rearing, the child's experiences in his relations with his family, will determine to a considerable extent the types of mechanisms which his ego employs. The amount of control and of gratification, the degree of support that a child has in his family, the personalities of the other members of the family, all of these things influence greatly the types of ways, or the type of skills, that a person develops in order to handle his mental functions.

Development

We know that there are some families that are free and easy, and others that are rigid in regard, say, to habit training, feeding, how they handle aggression, or how they handle dirt. Some families we say are very obsessional. We use that word a bit loosely, but if we tease the idea apart, you will find that we mean that certain ways of dealing with instincts are being used in a very rigid way. Obsessional people believe that you must never allow yourself gratification, must never have any loose ends lying about, that everything has to be tied up, everything has to be correct, nothing can be dirty, everything has to be clean and orderly, time is important. There are families with this type of atmosphere. And this type of atmosphere has a very obvious effect on the kind of personality that a child develops. You are not surprised in a family of this kind to find that the children are neat and tidy and unaggressive, or to find a very rigid control where there should be gratification. You also find families that are just the opposite, and here the children are the opposite. This may be partly due to the fact that the strength of the instincts, from the constitutional point of view, is also different.

So we see that these mental habits, these ways of life, are actively imposed on the child through the rules laid down in the family, rules as to how to handle aggression or sex or something else. But there is also a more passive influence, in that the child is presented with models. He sees the way his mother and father and siblings behave in regard to this, that, or the other situation; and he begins to copy them. He incorporates, takes into himself and builds into the structure of his personality, ways of behavior which he sees in the people around him whom he respects and loves.

This second type of influence is important. We can think of an individual who has had a large number of models, a large number of people who are meaningful to him and who handle many different kinds of problems in many different kinds of ways. If

the individual has managed to incorporate a wide range of responses, you get what we call a rich personality. You get a person who can deal with many different situations, and deal with them in a variety of ways. You get a person who is flexible. On the other hand, you get a restricted personality where the number of models has been restricted and the models themselves have been restricted in type. Such a person has a restricted number of ways of dealing with problems. So we may think of a richer or poorer personality in terms of the opportunities which an individual has had of being in contact with, being in intimate relationship with, a variety of people and seeing the various ways in which they have handled the stresses and strains of everyday life.

Here we have a link between psychology and sociology. Sociology has a great deal to say about role and role ascription, about the way in which a person learns certain roles. We too are talking about the development of personality through contact with people who play certain roles, about how the child can then identify himself with those people and incorporate their roles.

It is important to remember that this kind of personality development does not stop when a child reaches 4 or 5 or 6 years of age. It is much more obvious in a young child, and I suppose by the time one has reached 7 or 8 or so, the main outlines of his personality can be seen. But the incorporation of roles, the incorporation of defenses, and therefore the growing and development of personality, continues pretty well throughout life. It continues particularly in regard to one's professional role, to the professional personality, or persona.

Development of a professional role

In Boston we have recently been investigating the way in which adolescent girls develop the role of being a nurse; how they grow into nurses in a nurses' training school. We have studied this over a 3-year period. The girls come in as ordinary girls and they go out as nurses. The question is, what happened during that time? We have found that a very interesting and fascinating development takes place, with certain identifiable stages, in which the girl's personality changes in definite ways.

The important question, of course, is what kind of personalities at the time of entering are most likely to come out right at the end? Some of those who go in have a previous personality and previous background such that they cannot easily incorporate the new defenses, the new methods and mental habits, which are needed for a nurse. These will probably leave; or they will break down,

or have conflict and difficulties. Other girls have more suitable personalities and backgrounds. In this study we are trying to answer the question: "What should you look for in selecting girls to become nurses?"

This problem of selection is a very difficult one for any profession. One cannot simply take the mentally healthy or the intelligent or any other easily defined type of person. The fact is, there is no optimal type of personality which is suitable for all professions. Different professions make different demands. But the important thing for us to realize is that social workers, physicians, nurses, psychiatrists, everyone, as they go into their profession, develop their professional role. Everyone has a set of defense mechanisms that have become incorporated in his personality. Some of these are more effective, from the point of view of doing a particular job, than others. I suppose one of the big areas of research today is teasing out details on the limits of a particular professional role, say, of a nurse, or of a social worker. Where can you be flexible, and where can you be rigid, in regard to the requirements? What are the limits, and which edges can you try to shave off?

The Ego Ideal.—All this leads us to the concept of the ego ideal, which is of very great importance in this business of professional roles. This ideal is usually unconscious, but it has certain conscious components. It is the internalized image of the person that that individual would like himself to be. It is derived by elaboration from the models seen in the family and out in society.

Different cultures have different stereotypes of what the ideal person is. It is remarkable how these differ from society to society. What is regarded as an ideal in one culture would be considered a misfit, a deviant, a neurotic or psychotic in another.

Of course, the ideal is of very great importance in becoming a professional person. It is very interesting to see, in regard to this, the work we are doing with nurses. The girls come in with some romantic ideal of becoming a Florence Nightingale. Later they take as their model the actual nurses they see and admire, the senior nurses, tutors, and so on. Gradually they build up another ideal, one which is more attainable. And at a certain stage of their nursing development they have really become and feel themselves to be this nurse whom they wanted to be.

Probably there is some rhythm here which is important. That is, although we might hurry this development somewhat, I am sure it will always require a certain amount of time. Perhaps someday we can say just what the incorporation of the ideal of being a nurse or of being a social worker involves; and how long it takes to be completed.

Built-in stress

In becoming a nurse, there are certain obstacles which have to be overcome; there are certain stresses which are built into the situation and cannot be avoided. The process of becoming a nurse consists in handling these problems, with the support of the culture and with a certain amount of personal support.

Nurses are usually young girls when they become student nurses; usually they are in late adolescence. Part of their training consists in learning to take care of the intimate bodily processes of patients. This means a good deal of seeing and touching bodies of people, both men and women. Taking care of the bodies of men and women stimulates their developing sexual feelings. This is a stress situation, and no mean one, which may be both homosexual and heterosexual. A great deal depends on how this is handled. Some girls may handle it in such a way that they ward it off completely but as a result become quite mechanical in their nursing techniques. That is, they may turn people into dummies in order to protect themselves in this situation. I would say that this was a maladaptive defense which, however, is quite understandable. They will probably be able to find among the senior nurses others who behave in this way. But from the point of view of one interested in the mental health aspects of nursing, this is not a good solution. Our question is, how can these girls protect themselves from undesirable stimulation and at the same time continue to handle their patients as though they were people?

One can think of many other examples. In the public health nursing field, for example, the nurse must go around to all kinds of people. A good deal of her time is spent tramping up stairs to doors that are closed in her face. How is she going to react to this? She cannot go on living and working without adapting to this type of situation. She may adapt by turning away. "You do not want me? Well, so much for you. I will go on to the next place, where they do want me." But it may be that these are the very places where she is needed most.

The same thing applies to social work. There are certain built-in stresses, which are part of the ordinary routine work of the profession. How does the professional person, in building up his professional armor or technique or persona, whatever you want to call it, learn to be comfortable in this situation?

Or let us take medical students as an example. Medical students begin their professional career with about the same kind of sensitivity to interpersonal relationships as any other type of person has. Some of them begin with romanticized ideas. If you

drew a graph showing the sensitivity of medical students to interpersonal manifestations, you would find that it started at about the average level and went up a bit in the first year of medical study. During the 4-year course in this country, it remains static until about the first third of the third year, and then it suddenly begins to drop. If you compare a fourth-year medical student with a third-year medical student, in any kind of discussion involving sensitivity to human interest, you will find that the fourth-year student is much duller than the third-year one. He depersonalizes people. By the time he graduates, he is really quite a blunt person. During his internship, he moves still further down. He starts levelling off during his residency.

Dr. Hargreaves has said that his main goal as head of the Mental Health Division of the World Health Organization would be achieved if he could arrange matters so that doctors all over the world would be as sensitive to people as the man in the corner grocery store normally is.

This lack of sensitivity on the part of doctors is a bad thing, but it is understandable. These young men come into clinical work their third year and are suddenly faced with people who have all kinds of problems. If they remain sensitive to these problems, if they allowed themselves to be affected by the problems, many of them would break down or would be so upset emotionally that they would not be able to learn.

If you look carefully at the techniques of medical education, you will find that in the third year students are brought into contact with physicians who teach them that people are not people at all, but merely biochemical systems. Soon these highly scientific teachers become the students' role models. From this comes a blunting which enables the medical student to go on and learn all kinds of things about the various systems without being upset by the fact that this man is dying or that this one has a family of six children, and so on. The medical student does not have to identify himself with those men and so he avoids difficulty.

Social workers have ways of dealing with similar situations. In schools of social work steps are taken to make sure that the workers remain sensitive in their interpersonal relationships. But this is accomplished by means of a very elaborate system for picking up the casualties before they become real casualties. Students are helped over these various crises as they arise. In other words, there is a supervisory system which produces as a finished product someone who remains as sensitive to interpersonal relationships as they were before, and someone who has not broken down. I suppose there are some who do break down.

Medical schools are beginning to be aware of this problem. Western Reserve, for instance, is attacking the problem by copying the social workers and providing individual supervision. They are trying to maintain the patients as human beings, and to give the students role models of people who practice and preach the idea that a patient is a person. In the traditional medical schools, on the other hand, a patient is a case.

For example, this one is an acute appendicitis. It is not a man with acute appendicitis. Or this one is a gall bladder. The important thing is, if you turn the problem from a gall bladder to a man with a home and a family and a gall bladder, who will be in a weakened state after you cut out his gall bladder, and who nevertheless has to go into the community and work and so on, if you do that, your students are likely to break down. You must do something else. You must help them to handle these emotional difficulties. You have to help them to acquire a professional distance where they can empathize without identifying.

What happens is that you have a professionally, or culturally, accepted set of stereotypes. These are fantasies, because after all patients are not this way, they are human beings. When you say, "This is a gall bladder," you are perceiving a human being through glasses colored by a professional culture, which imposes certain stereotypes.

Many educators did not have to come to the psychiatrists to learn that they were role models. They had been conscious for a long time that they were role models. They set out to be. In the English public schools, to take another example, there has been a good deal said about how you have to have the right kind of school teachers, sports, clean, honest fellows, and all that, if boys are going to become the right kind of Englishmen. They have there an institutionalized system for developing role models.

The Ego Ideal

It is an important fact, since the ego ideal may be taken from different models, that the different models may be incompatible. Let us take the simplest example, of a child growing up with a mother and father. The mother's values may be different from the father's values. I suppose if the child were a boy he would tend to take in more of his father's values and less of his mother's. But we all take in some of the values of both of our parents. Where you have incompatible values in the two parents, you sometimes get into difficulties.

During adolescence the individual has no real feeling of self-identity. He does not know what he wants to be or what he is. You can think of adolescence as the period when the child is trying to find himself. Now, if the values of the father and of the mother are in conflict, or if the values of the parents are in conflict with those of outer society, so that the society sets up stereotypes of hero figures which are not the same as those the parents have, the child is caught in a conflict. How can he unify or integrate for himself the ideal of what he wants to become?

Very often during adolescence the child will revolt and throw over altogether the values of the parents. It seems to be part of the culture of American society that, during the teen-age years, the parents take a back place and leave the child on his own, to go looking outside among the other teen-agers for his role models. But you get pendulum swings here, throwing over certain models and going after others, being disappointed in these and so on, until the individual matures. When he matures, he gets an identity of his own. This identity comes when he manages to unify his various models into something he feels is worth while for himself.

The Superego

Associated with the ego ideal, of what the person would like to be, is the superego, which represents not the internalized value system but the internalized controlling system. Parents and society figures tell the child what he has to do, and after a while he incorporates these into himself. I am talking now about the unconscious part of this. The conscious manifestation we all know as conscience.

It is interesting that this process, too, is very much dependent upon the particular culture. There are some cultures where there is much less in the way of internalized controls than there is in other cultures. For instance, in certain oriental cultures that I am familiar with, Middle Eastern cultures, a person left to himself will do all kinds of naughty things without feeling guilty.

I was once asked by the Ministry of Justice in Israel to examine a murderer, a Turkish fellow who had killed his cousin because the cousin had cursed him. A curse among these people is much worse than a blow, because the culture still works along the lines of magical thinking. In this culture, if someone said, for instance: "A camel will walk over your father's grave," it would be a terrible thing. If a camel walked over your father's grave, it would defile your father's grave, and that would be very terrible.

In the case I was investigating, the cousin had said something

like that to the man. According to the story he told me, his cousin ran toward him cursing him in this way. He said: "The knife was in my hand and I stuck it into him. I felt very sorry after I had done this and I couldn't understand how such a small knife could kill him. I was very annoyed with the knife and I went and broke it." The knife was, I suppose, about 5 inches long! He said, "I was very sorry, indeed, that my cousin had died." But there was no sign of guilt at all.

I asked him, "How did it happen?" He said, "Well, the people didn't tell me to stop. If those people had only told me to stop, I wouldn't have done it." He was expecting the people around to control him. According to him, if someone had said, "Stop," he would not have done it. I believed him. He was sentenced to about 10 years but he was quite a decent fellow. Afterward, when I visited him in jail, the people in charge said, "This is not a murderer. This seems to be a pretty ordinary, decent sort of fellow."

We ran some tests on him, and the psychologist who made the tests said, "You know, I cannot find any superego structure here. This fellow hasn't got one." In that particular society there is very little internalization of control, because the people live in close proximity to one another, and are surrounded at all times by other people who effectively control them. Because of this, they do not need to internalize the control. If I had not known this person was from this particular culture, but had thought he was from California, say, I would have said, "This is a psychopath. This is a fellow with a disordered personality." But in his culture, he is probably an ordinary person.

I am sure that this man had some internalized controls. It is just that our instruments, developed for measuring different personalities in a different culture, were not effective in isolating them. But I am equally sure that the type of superego development we see in our culture was not there.

This man was a law-abiding citizen as long as the culture went its ordinary way. According to his traditions, the people standing around in the courtyard when his cousin ran toward him, should have said, "Don't do it." But something went wrong, I do not know quite what. Possibly it had something to do with the fact that this was the Sabbath day. These are very religious people. They may have been upset when the cousin used swear words on the Sabbath. I do not know. One would have to analyze the whole situation very carefully to find out why the people in that group failed to do what was expected of them.

I think a culture that had no controls would soon cease to exist. The only question is whether the controls become an in-

ternalized, intrapersonal, enduring structure, or whether they continue to be actively, in the here-and-now situation, a set of interpersonal forces.

Interpersonal Relationships

The internalized superego is in constant and continual interaction with people in the environment. What I have just said about the Turkish boy shows that, where there is very little in the way of internalized control, the person's antisocial behavior is controlled by actual here-and-now interaction with the people around him. And even when you have an internalized superego, there is a continual and actual interplay between the person and the people around him. You do not have a control which is completely independent of continued social interaction. In other words, even though each of us has a more or less crystallized set of internalized controls for our activities, we are also, at every stage of our life, very much influenced by what the people around us say and think and by the way in which they impose their sanction.

However, it is not just any kind of interaction that counts. The kind of interaction that is important is the interaction of key people, emotionally important people, meaningful people. It is important to realize that the difference between, say, the people one happens to be sitting next to on a plane or a train and the people with whom one builds up stable relationships based upon a complicated and protracted interchange is very great. If we are talking about a child, the key people are those who satisfy his needs for love and affection, for control, for gratification, for dependence, and independence. These are the emotionally meaningful people for that child. And of course, these are the members of his family.

As we grow older we continue to have emotional needs and to have in our environment people who are linked with ourselves. These are the emotionally meaningful people, the people on whose death we would feel bereaved, the people who influence us in our activities. These people influence most during crisis periods. I will speak about this in a few minutes.

But first it is important to realize that when we speak about meaningful interpersonal relationships we are speaking about something quite specific. We are speaking about a specific set of people around you. This is not just the family. As one grows older this may include some people in one's work group. It may include some people in one's professional life, or social life, or religious life. Or it may include the care-taking agents that the community provides when one gets into trouble.

The capacity to initiate and maintain satisfactory interpersonal relationships is one of the main functions of the ego. If you wanted another measure of mental health, I think you could say that mental health is measured by a person's capacity to initiate and maintain good interpersonal relationships.

This is an important fact, not only because it is a here-and-now measure of capacity, but also because the rest of the ego's functions are developed via this bridge. In other words, if a person, a child, does not have the ability to establish good emotional relationships with other people, he does not develop the other aspects of his personality, which cannot be developed except through this interchange with people.

Here I would like to go back to the question of perception, which may be reality based and which may not. Take the case of a child who has had unfortunate experiences in early interpersonal relationships. Perhaps he has not had the mother or the father or the other figures he needed at a particular time; or he has had them but has had disordered relationships with them. Such a child is not likely to develop in the flexible way that we have been talking about. He is likely to become fixed in such a way that his developing sense of reality is crystallized, becomes defective. He tends then to misperceive the people around him according to certain stereotyped patterns. For instance, he may see everyone as critical and persecuting because he happened, as a child, to have, a critical or persecuting mother or father. It is astonishing how grotesquely people can misperceive for reasons like this.

CHAPTER III

Ecological Ideas Regarding Mental Health and Mental Ill-Health

Concept of Stress

We must remember that the person, the personality, is constantly in contact with other people—with the smaller family group and the larger group of the culture. These groups affect the individual when he has a problem to face, especially if this problem constitutes a stress. What do we mean by a stress?

A stress is a situation in which one has an important problem which cannot be solved immediately by using one's old habits of dealing with problems. Under these circumstances, one must alter his way of functioning. He must summon up whatever strength he can. In order to do this, he will rely not only upon old habits, old mechanisms, old ways of manipulating or organizing drives in relation to the outside world, but also upon external support. This one gets in two forms, cultural and interpersonal.

Support of the culture

In a crisis situation we rely upon the external support of our culture, of our traditions. Our society tells us that when we have a problem like this, we should go about solving it in certain ways.

Take, for example, a problem like bereavement. This is a stress situation. A person who was meaningful to you, important to you, has gone from your life. You have no built-in way of reacting to this, and at the moment it is an insoluble problem. How are you going to handle it?

In most cultures certain ways are laid down as the "correct" ways of dealing with such situations. These usually involve complicated rituals, religious traditions, and so on. The interesting thing is that when psychologists examine reactions to bereavement, to analyze out the most appropriate ways of handling such things, they recommend procedures very similar to those laid down by many cultures.

In the Jewish tradition, for instance, when you lose one of your close relatives, you must retire from life for a period of 7 days. Custom prescribes just how close the relative has to be. It is interesting that the relatives listed are just those relatives who are most meaningful to us from the psychological point of view, mothers, fathers, brothers, sisters. Custom requires that you sit there in the house, and that people come and visit you, and mourn with you. The people who visit you are supposed to talk about the deceased. At first sight this sounds cruel, like turning the iron in the wound. But research has shown that it is by constantly thinking about the person who has died and about one's life in relation to that person, that one is able, finally, to adapt to his loss. Considerable emotional work is involved in continuing to think, "I did so and so with him, but now he's not here any more. What shall I do in this part of my life? I used to rely on him." Going over such thoughts, the bereaved one feels sorry and weeps. The mourning ritual, which is laid down in Jewish tradition and in most other traditions too, helps the process along.

Many religions have rituals of weeping especially in the oriental cultures. There are hired wailers who come to funerals and wail. When these people wail, the bereaved person identifies himself with them and weeps also.

According to present-day research this weeping, crying, feeling of the pain, constitutes part of the adaptive process. This represents a certain amount of work, which in turn, requires a certain amount of time. Lindemann has called this "grief work." It is desirable that the culture support the individual and push him into this work. Grief work is painful and, left to himself, an individual might turn away from it, might try to put on a bold front and forget it. It seems that when a person does that and avoids working through the grieving process, all kinds of bad effects follow.

So we see how the traditions of a culture may be very helpful. In the Jewish tradition, for instance, there is one period of mourning which lasts for 1 week. This is followed by another kind of mourning which goes on for another 3 weeks, making a 4-week period in all. Lindemann, in his researches on mourning, has shown that 4 to 6 weeks is the average time required for the mourning work to accomplish its function. We can imagine how this and other cultures, being, so to speak, the distilled wisdom of the people, have discovered that about this length of time ought to be spent in mourning and have provided for it in religious rituals.

We all know that conflict is an important factor in neurosis. Here again the cultural traditions make an important contribution to the mental health of the individual.

The culture lays down rules as to what is to be done, which leave little room for conflict. Wherever you have an integrated culture, and an individual not in tension with his culture, you will find a minimum of neurotic disturbance.

Interpersonal support

The other type of support which a person may get in a crisis period is individual, interpersonal support. That is most easily seen in the family circle. One can think of the family as a kind of emotional nest for the individual. We are not talking just about children now. We are talking about grown-up people, too. Think of the man going out to his work and facing all kinds of problems there. He comes home at the end of the day and shares his problems with the other people around the family table, in one way or another. This means that the other members of the family understand what he has had to put up with. And this understanding implies support. Families differ; some families have the kind of atmosphere that supports the individual more than others do.

When an individual is facing difficulties in his life, he may be using his own inborn strength, strength which has grown as a result of mental habits developed during his childhood and subsequently. If he has had a good relationship with a number of role models, he will have a rich array of skills for dealing with all kinds of problems. In addition, he has the family which surrounds him and the culture which surrounds them all. You can think of him from an emotional point of view as resting within the nest of the family with the family resting within the nest of the community.

But it is important to remember that you can have tensions between any of these. You can have tensions between the family and the community; and you can have tensions between the family and the individual. This brings us to the concept of equilibrium.

Concept of Equilibrium

Most of the time, people manage to adjust themselves, to find a mean between the internal demands of the instincts and the demands and pressures of external society. This equilibrium may alter suddenly when either the demands from inside or the demands from outside change. For instance, during adolescence the internal demands change. This is mainly due to the sexual needs which suddenly increase in strength. But you may get all kinds of other internal changes. Or you may get changes in the external demands.

How one meets this crisis period, when the equilibrium is upset,

depends not only on the strength he has developed in the past but also on the here-and-now, present-day supplies of strength he is getting from the people around him.

I think we can say that in childhood there is an almost constant state of disequilibrium, a constant state of recurrent crisis. The child as he grows older is constantly changing internally, and society is constantly changing in its demands upon him. During these recurring crises, in which his own strength is gradually increasing, the child is also turning to the people around him to lend him a hand. Of these, his family are the obviously important ones, but there are also others. For instance, the kindergarten teacher, the other teachers in the school, the school nurses, all have important meanings to him.

About a year ago we began an investigation at Harvard of the way in which families, as units, react to certain crisis situations. We were trying to discover the range of ways in which a family adapts to, say, the birth of a child with a congenital anomaly, or to the birth of a premature baby, or to some member getting tuberculosis. These are stress situations, crises. When we investigate a number of families, taking a random sample of the population, we find that there are various effective, adaptive, ways of dealing with them. And there are various maladaptive ways. If we develop this, we may be able to do the same thing here that Erich Lindemann has done in regard to bereavement, and provide answers to the question: "Is this person doing his grief work effectively or is he taking an ineffective path which will lead him into difficulty?"

Family equilibrium

Before going farther, we must decide on how to describe a family. We all talk about families as units, but this is a hard thing to conceptualize. Suppose we have a father and mother and two children. Some people analyze the unit in this way: There are the husband-wife relationship, mainly without reference to the children; the father-mother relationship; the father-child I; father-child II; mother-child I; and mother-child II. They add all this up, and hope that it forms some sort of pattern.

But I think that, given a family of A, B, C, and D, the relation between A and B is influenced by the relations between D and A and C, and A and D, and B, and so on. In other words, if you take any of these two-body situations and try to analyze it, you will realize this relation is influenced by the other relations in the family circle. The relation between mother and child is very much influenced by the relation between mother and father and the sexual

relation between them. Does she as a wife get what she wants from him as a husband? If she doesn't that may influence her relation with the child.

It is important to realize that tensions of any kind, in any of the two-body relations in the family, are going to affect the others. Moreover, there should be a certain amount of free communication among all members of the family in order for any single set of two-body relations to remain undisturbed. For instance, in a family group which is disorganized, there are likely to be blocks in interpersonal communication, and a negative feeling tone due to mutual suspicion or hostilities among the members, and those will affect negatively many or all of the two-body situations. This need not necessarily be so, but it is very likely to be.

Needs of Members.—As we have said before, not only children but also adults have emotional needs. For instance, there is a need to love and be loved for one's own sake. A child needs love and affection. An adult needs love and affection too, but he also needs to be able to love and to be affectionate to someone else. An adult, like a child, needs support in relation to tasks, but he also needs opportunity to support others. The same thing applies in regard to control. An adult needs to be controlled in relation to instinctual gratification, but he also needs the possibility of controlling others. And similarly with gratification. An adult also needs to be part of a group where he can feel free to relax and be secure. He also has a need for personal achievement in material and spiritual matters.

Reaction to Needs.—The family group provides an opportunity for the expression and gratification of these needs. (To be sure, this is not the only opportunity; these needs may also be expressed and gratified outside the family.) However, some families provide more gratification than others. In some cultures you expect to find such needs gratified almost entirely in the family; in others you expect to see them gratified, for instance, in the religious sphere, or the social sphere, or the work sphere. The set of people who surround you and toward whom these needs for love, support, control, et cetera, are directed, may be called one's "entourage."

All of us can call to mind families in which the needs of the individuals are not perceived, not respected, not gratified. This is a chronic situation. The family members are chronically in a state of frustration, and this may easily lead to emotional ill-health in one or more individuals. And we can all think of other families where the needs of the individual members are perceived, and respected, and gratified.

I keep repeating those three words—perceived, respected, and

gratified—because I feel that they are important in understanding the family unit. We are trying to analyze a family from the point of view of its capacity to promote the mental health of its individual members. Some families are more able to do this than others. Suppose you move into a family in which an individual member is in trouble, and you ask yourself: How does the family come to his aid? How does it react to his needs? I think you will find that one important factor is the extent to which the family is able to perceive the individual's needs, or, in reverse, the extent to which they see their individuals as stereotypes.

If the needs are perceived, the next question is: Are the members of that family respected as people, or do they say of one another: "To hell with him. Who's interested in whether little Johnnie wants to do this or that or the other?" You often find that one member of a family is made a scapegoat in this way; in other words, his needs may be perceived, but not respected.

I feel that perception and respect are more important than gratification. Sometimes a family is unable to gratify the needs of the members. If an individual knew that his needs were perceived and respected but that the family was unable to gratify them, I don't believe that he would suffer very much from this.

All of these factors become very important at a crisis period. Let us take, for example, the birth of a baby with a cleft palate. The family may handle the problem in a mutually supporting way, but it has to reorganize itself to do so. It was expecting a normal baby and has an abnormal one. All kinds of feelings of guilt are stirred up by this. There are all kinds of things that must be done for a baby with a cleft palate, involving considerable economic burden. The family's previous equilibrium is going to be upset. The question is: How does it reorganize itself to deal with the problem? Does the new organization give jobs to the different members which are in keeping with their abilities, or does it give people jobs which they cannot do?

All families give their individual members certain jobs, or roles. You can say that a family is a healthy one if it gives Jimmy, or Willie, or father, or mother, a job which is within the capacities of those particular individuals to accomplish. That is, the healthy family perceives the individuals' needs and abilities and also the needs of the family and balances these. In this way it establishes an equilibrium.

But you also get families where jobs are doled out regardless of individual capacity. Such a family might reorient itself to the birth of a baby with a cleft palate by directing all its attention to the baby. They might feel that they had to make reparation for

an injury done to it. In such a family, the mother might remember that she carried the 2-year-old up and down steps during pregnancy and feel that this was what caused the baby to have a cleft palate. She would feel guilty about that. She may feel guilty about other things too. She may even blame the 2-year-old. In this case, she might turn away from him and put all her attention on the injured baby. This is a pattern with which we are all familiar. Little Johnnie, who up to this time had been the center of interest, now gets pushed away. His needs are disregarded. He is called upon by the family to play a role of a 2-year-old who should not have any attention at all. That is his job. "You keep your mouth shut and don't ask for anything, and if you do ask for something you don't get it. If you get jealous you get beaten up and put to bed." An equilibrium might be achieved in this way. The family will have solved the problem of the baby with the cleft palate as they perceive it through their stereotyped perceptions. They have decided: "This is the problem of the two of us doing something naughty and getting punished for it. We now have to repair the damage by lavishing a lot of attention on the baby, taking him from clinic to clinic and so on." But Johnnie bears the brunt of this solution.

This is an example of a maladaptive reaction. Usually this kind of solution does not do the baby any good either. What the family is doing is not so much attending to the baby as reacting to their own needs of the moment, attempting to appease their guilt feelings. The needs of Johnnie, the 2-year-old, are no longer perceived, or if perceived they are no longer respected. Certainly they are not gratified.

In contrast to this, one can think of a family reacting in an entirely different way. Here they would perceive the reality of the baby with the cleft palate and also 2-year-old Johnnie's needs. They would see what it would mean to him to have a baby coming into the family which would require a lot more attention than other babies do. Johnnie will not like the fact that more attention is going to be paid to this baby, but there is no way out of that. The parents can show Johnnie that, although they do not lift him up and cuddle him in the way they used to do, this is not because they are not interested in him, it is because at the moment that is impossible. I think Johnnie would accept that.

I hope all of this has given you some feeling for the way in which we are approaching this problem of the reaction of families and for the ever-present effects of the atmosphere in the family and of the different interpersonal relations upon the emotional health of the individual family members.

CHAPTER IV

Emotional Implications of Pregnancy

We have said that the mother is not the only important person in the child's life, although she is the most important person in the first year, or the first 9 or 10 months of life. We will discuss later whether or not someone else can do the mothering. But so far we have been talking about the mother person, not the biological mother.

Now we must turn our attention to the biological mother. I want to consider some of the emotional implications of pregnancy, some of the emotional manifestations of pregnancy, from the point of view of the influence these factors have on the future relationship between the woman and her child.

The emotional manifestations of pregnancy are important to us for two reasons. In the first place, if we know something about the way women react emotionally to pregnancy, we may be able to make them more comfortable. A pregnant woman has a rather difficult time generally, and I think that it is legitimate to want to make her as comfortable as possible.

But from the point of view of preventive psychiatry, this is a minor goal compared with the second one, which is to be able, through our knowledge of the way the woman is reacting during pregnancy, to intervene in the course of events and prevent the development of a disordered mother-child relationship. I think we could establish a healthy and undisturbed mother-child relationship for at least the first few months of the child's life. I would not claim more than that for work done during pregnancy, because the mother-child relationship, like any two-body relationship, does not move in a single direction. It is a circular system. The mother stimulates the child, and the child stimulates the mother. In other words, the mother is constantly being affected by the child's behavior, and in turn affects the child's behavior, which again affects the mother. And so it goes, round and round.

Once the child is a few months old, he becomes a very active partner in this two-body relationship. So, if you are trying to predict from emotional changes and manifestations during pregnancy

what kind of mother-child relationship there will be, you can only speak about the very early relationship. There is a difference here between prediction and prophecy. If you try to say what the mother-child relationship is going to be at one year, you are a prophet, not a predictor. You cannot know how the child will develop, what the vicissitudes of his personality development will be during the first year of life. So you cannot know what kind of child the woman will have at the end of the year, and this would determine to a great extent whether she had this, that, or the other kind of mother-child relationship.

This problem—of the relation between pregnancy and the following mother-child relationship—is something we have very little knowledge about. There are a number of reasons for this. For one thing, in order to investigate the emotional life of a pregnant woman, one has to have contact with pregnant women. And in order to have contact with pregnant women a psychiatrist has to build up a partnership with an obstetrician. But obstetricians and psychiatrists have a very hard time working together. Perhaps social workers and obstetricians have a hard time working together too, but certainly psychiatrists and obstetricians have. This is not confined to this country. I have had the good fortune to work with obstetricians in various parts of the world, and there seems to be something built into their professional armor which makes them “leery” of looking too closely at the emotional life of the women they are dealing with every day.

This might be because they know that if they looked they would be in for a lot of trouble which would disturb their present routines. They are encouraged in this attitude by one of the manifestations of the emotional life of a pregnant woman. Often a woman is very obviously upset when she comes to the end of her pregnancy. But she goes out of the hospital 5 or 6 days later as happy as a queen, bearing her baby, and feeling very grateful toward the obstetrician. She gives him thanks in no uncertain terms. He feels very proud. He has delivered a healthy baby, and the mother is happy. What could be better? He then looks back and says, “All you have to do is tell her everything will be all right, and everything is all right.”

The obstetrician does not see the woman after those 4 or 5 days, and has no way of knowing what kind of relationship she is going to have with that child 4 or 5 weeks later. As far as he is concerned, the result is good. There is a live, healthy baby, and a healthy mother. This helps him to feel that whatever emotional reactions there are during pregnancy are not worth bothering about very much.

The obstetrician also knows that women are very upset at the beginning of pregnancy. As a rule, he tells them, "Pull yourself together. Everything's all right." And in quite a short time they are all right. This is due to a very significant fact about pregnancy, namely, that it is a dynamic unfolding process, not only from the physiological point of view, but from the emotional point of view as well. If you are going to say women are this way, or that way, or the other way during pregnancy, you must specify whether you are talking about the beginning of pregnancy or the middle, or the end, because the situation changes.

From our point of view pregnancy must be recognized as a biologically determined, psychological crisis. During pregnancy, both the intrapersonal forces in the pregnant woman and the interpersonal forces in her family are in a state of disequilibrium. This is a very important fact. It would be a good idea for us to think in terms of the pregnant family, rather than the pregnant woman. From the psychological point of view the whole family is pregnant, and the future mental health of the woman and of the family may be determined by how the balance swings during this period of disequilibrium. This balance may weigh down in one or another direction quite spontaneously or it may do so as a result of appropriate pressure exerted by key figures in the environment.

Causes of Emotional Changes in Pregnancy

Now we must consider the causes of emotional changes in pregnancy? Obviously, there are two kinds of causes, the somatopsychic and the psychogenic. First there are the somatopsychically induced emotional changes and manifestations. These are produced as a result of hormonal and general metabolic variations. Complicated alterations take place in the hormonal and general metabolic systems during pregnancy. As Therese Benedek⁵ of Chicago has shown, the existence of certain hormones in the blood influences the mood and colors the fantasies of the pregnant woman, or of any woman for that matter. Some of Dr. Benedek's work indicates that the kind of fantasies a woman has varies according to the state of the menstrual cycle, and in particular, according to the secretion of progestin. Progestin is one of the hormones secreted during pregnancy. The general introversion and passivity of the pregnant woman may be related to this; as may the increase in her primary narcissism. That is, the increase in the energy which a woman turns in on herself during pregnancy may be due to these hormonal changes.

⁵ Therese Benedek: *Psychosexual Functions in Women*. New York: Ronald, 1952. 435 pp.

There are also psychogenically induced changes. These are frequently linked to the reactions of the woman to the sexual aspects of the reproductive process and to pregnancy as the result of sexual intercourse. As pregnancy develops, a woman tends to forget this and to focus her attention on the motherhood aspects. But in the beginning, pregnancy is seen in its reproductive and sexual aspects. Any conflicts which a woman may have in her sex life are likely to be stimulated by the fact that she has become pregnant. The vicissitudes of her own previous sexual development are likely to be mirrored in her attitudes towards pregnancy.

Psychogenic changes may be related to the development of a role. A girl who is going to assume the role of a mother has certain ideals of what a mother is like, or of what a mother should be. She has models, mainly her own mother as she saw her when she was a child. Usually the girl has forgotten what her ideals are based on.

Last week I was visiting a friend who had just had a baby, and who also had a little girl aged $2\frac{1}{2}$. The mother excused herself to go in the other room and feed the baby, and about 5 minutes later the little girl said, "Will you excuse me a second? I have to go and get my baby." She came back with a doll and sat down and said again, "Will you excuse me." Then she lifted up her dress and put the doll to her breast and patted it and soothed it. She sat there quite happily doing what she had seen her mother doing and holding the doll in the way she had seen her mother holding the baby. The odds are that when that little $2\frac{1}{2}$ -year-old grows up and comes to feed her own baby, she will not remember the way her mother did it, but the way she will carry out breast feeding, providing it is the pattern at that time, will probably be influenced to some extent by the forgotten memories of this past experience.

Some of the difficulties women have in relation to breast feeding may be related to the fact that many girls in our generation never saw their mothers breast feeding. Now the pendulum is swinging the other way; women have to breast feed, and they have never seen anyone do it. So the relationships of a girl with her mother are going to mold to some extent her reactions to her own pregnancy and to becoming a mother herself.

Emotional Changes in Pregnant Women

At all stages during a woman's pregnancy, there are alterations in the dominant mood, or mood swings. These have no relation to external factors, to the things one is likely to ascribe them to. A girl does not become depressed because she did not want a baby, or happy because she did want one. There are some women who, preg-

nancy after pregnancy, have what can only be described as a beatific feeling throughout the entire period. They feel better than they ever felt when they were not pregnant. Some women keep on becoming pregnant because they enjoy this so much. We have a girl in our Harvard Clinic who keeps coming back, time after time. We are all convinced that she is an example of this, because her appearance changes so greatly. When she is not pregnant she is a rather colorless person, but when she is pregnant she is vivid and happy. You might say she is really addicted to pregnancy.

These mood swings do not seem to be for any apparent reason. The person suddenly becomes happy, or suddenly becomes depressed. Women who have not been told about this in advance sometimes get very frightened. They have heard stories about psychoses of pregnancy, and are frightened by their own mood shifts. A girl should be told often, and from the very start, that many people's spirits alter during pregnancy. The physician should say: "Does that happen to you? Well, if it hasn't happened yet, it may."

Linked with these characteristic emotional changes, are others, equally characteristic, that are not so frightening but somewhat annoying. There is an increase in emotional lability, irritability, and sensitivity. That is, the pregnant woman will laugh more easily, cry more easily, and become angry more easily than she did when she was not pregnant. The husband will say some trivial thing, and the woman will immediately burst into tears, or get furious at the other children. The family equilibrium will be helped greatly if the husband knows ahead of time that such things are likely to happen. This will make things much easier for him. The woman should be helped not to feel guilty about them. No one should think that she is getting spoiled or anything like that. They should realize that these things just happen, we do not know why.

You very often, in fact almost always, get changes in sexual desire and performance during pregnancy. Here anticipatory guidance is very important indeed. Most pregnant women will have some change in their sexual desire, sometimes it goes up, sometimes it goes down, sometimes the performance is better. There are some women who have an orgasm for the first time during pregnancy. In many cultures, it is not regarded as normal for a woman to have an orgasm, but in this country, where there is such a high premium on orgasm in a woman, this is very important. A woman should be equal to a man in many respects, including the respect of having orgasm during intercourse. A woman who, because of pregnancy, suddenly loses her capacity to behave in this way, or loses sexual desire, may get into emotional difficulties, and the whole future of the family life may be endangered. This is especially true if, along

with a lack of sexual desire and frigidity, she is also inclined to increased irritability. The husband may then feel that he is having a bad time all around. The woman may feel worried and anxious and guilty about this, and may fear that her husband will turn away from her, which sometimes happens. Very difficult marital situations may arise from this. These can be avoided very, very simply, just by telling the woman, and her husband too, if you can see him, quite early in pregnancy: "Now, look here; I'm not saying it will certainly happen, but it's very likely that your sexual life will change, just as your mood changes. Don't worry. It's perfectly normal."

Many women are very shy about discussing this matter. They are especially shy about discussing it with the obstetrician. And the obstetricians are shy about discussing it with the women, too.

Introversion and passivity

Now we come to what is perhaps a more interesting aspect of pregnancy, namely, the increased introversion and passivity. This is one of the most characteristic changes in pregnancy. It occurs in almost all pregnancies around the end of the first trimester, and gradually increases to a peak at about the seventh or eighth month. The woman who may previously have been quite an outgoing person and whose role as mother and wife may have been that of a giver, an active person, now changes, either gradually or suddenly, as a result of biochemical changes. She becomes someone who wishes to receive instead of to give—a person who is preoccupied with herself and lazy. She has increased need for love and affection. She wants demonstrations of love, not only in the form of kisses, but also in the form of the husband doing the dishes or cleaning up the house. You can think of a woman in this situation as a kind of battery that has to be charged. Unless she gets adequate love and affection during this period she is going to be impaired subsequently. We all know that a woman needs increased vitamins and proteins during pregnancy, and that if she does not get these she is likely to have all kinds of difficulties and complications. In just the same way, she needs increased supplies of love and affection and, if she does not get them she may have difficulty afterward in giving love and affection to her child. This too is an area where anticipatory guidance is tremendously important. Actually, what is given here is more than anticipatory guidance; it is manipulation of the emotional environment. This is an area where the care-taking agents can do a lot of good very simply.

Care-taking agents do not give increased love and affection. That is not their job. But they can see that the woman gets more love and

affection by working through people in her entourage, in her family, such as her mother or her husband, whose role makes it their special prerogative to provide these increased supplies. Emotional blocks may arise, which the care-taking agent can help to remove.

In our culture, it may be very difficult for a husband to understand the changes that are taking place in his wife. She used to get up and get his breakfast and behave as a wife should. Now she is asking him to get up and make her breakfast. He may think she is exploiting the fact that she is pregnant, especially if, at the same time, there is a decrease in her sexual performance and an increase in irritability, and in addition, she is asking him for extra love and affection. But what we know of the life of a pregnant woman makes us realize that this change in attitude is probably not consciously directed or controlled on her part. There has been a switch in her emotional situation. She is no longer the nurturer, but the one who wants to be nurtured. Of course, some women, who are ready to exploit anything, may exploit pregnancy too. But we might as well give them the benefit of the doubt.

A husband is likely to be worried by this sudden turnabout on the part of the wife, who was formerly his equal and has now suddenly become dependent. He may be afraid she is going to be spoiled, and may even hold back his natural impulse to shower more love and affection on her. A nurse, or obstetrician, or social worker, can be very helpful here. With just a little explanation, the husband can be helped along the path which he may have wanted to take anyway. He can be helped to see that there is no reason why he should not be a little more demonstrative, and that by doing so he will be an active partner in preparing for the baby.

Changes in equilibrium between ego and id

There is another, characteristic change of pregnancy, which I feel is even more interesting than the one we have just been discussing, and which you will not find mentioned in the literature at all. It is one of the findings of the Harvard Family Health Clinic study, namely, that during pregnancy there is a characteristic change in the equilibrium between the ego and the id.

I assume you are all familiar with the term *id*. It represents the unconscious precipitate of the bodily needs and urges, the instinctual life of the person, which is not present in consciousness. Usually, the ego protects itself against these instinctual wishes and needs by repressing them. These internal, primitive, sexual or aggressive appetites and desires are constantly struggling for expression. Their demand to come out and be expressed exerts a pressure

on the ego, which however controls them and keeps them under lock and key.

During pregnancy, this equilibrium alters somewhat and the ego allows a great deal of id material to come to the surface. And all kinds of fantasies and needs and wishes, which were previously unconscious, are now allowed out into consciousness, without producing as much anxiety as you would expect. It is as though during this period the ego, probably as a result of its increased strength due to metabolic changes, does not mind living with these previously unconscious appetites.

This is a peculiar picture, which, apart from pregnancy, you would expect mainly among people suffering from a psychosis. During psychosis, these unconscious instinctual needs come to the surface and are allowed out; a schizophrenic, for instance, will talk as though his unconscious were conscious.

The same kind of thing occurs in pregnant women, except that the schizophrenic has a disorder in his awareness of reality and a pregnant woman does not, unless she happens also to be psychotic. She knows very well that these fantasies are fantasies and that she should not talk about them. But she is aware of them. They come out fairly often in her conscious thoughts and her dreams abound in naked, primitive fantasy material. The defense mechanisms she has used in the past to keep such things under control are relaxed. If a psychologist takes a Rorschach on a pregnant woman, he may come to you and say, "This woman is very ill." And if you give him ten pregnant women to test, he would probably say, "They're all very ill." If you say, "No, they're just pregnant," he will answer: "But look at this picture; there are very strong suggestions of schizophrenic processes here. The defenses have crumpled." Well, the defenses have not crumpled; they have been allowed to die down, because the woman does not need them.

If you talk with pregnant women you can elicit this kind of material. I suppose in the past no one has talked with pregnant women except other pregnant women. They spend a lot of time in talking and it would raise your hair if you could hear what they say.

These unconscious things that are coming to light are old problems from childhood, which were not solved properly and were repressed. This is tremendously important, because if these old problems come to the surface, the woman has an opportunity to find new solutions to them, and she may find better solutions than the ones she found as a child. Very often that happens spontaneously. After all, the woman is grown up now; she is better able to deal with problems of all sorts, and these problems now relate to the past.

Most people working with pregnant women know that you very often get a curious spontaneous maturing process during pregnancy. The woman becomes a much more mature individual. This is because she has found more satisfactory solutions for some of her old conflicts.

Almost any kind of problem may emerge at this time but certain ones are found more often than others because they are stimulated by the specific context of the pregnancy. These are problems related to the mother or to siblings, and a whole set of problems related to sex, particularly problems arising in adolescence. Characteristically, you get problems of masturbation coming up to the surface. In the case of a girl who had a difficult time during adolescence and felt very guilty about it and then forgot about it, you will find such material coming to the surface, floating up more and more as the pregnancy progresses.

As these problems come to the surface, the woman is given an opportunity to solve them by using her unborn child. That is, she may weave a solution into her developing relationship with the baby. She does this, usually, by identifying the baby with some significant person involved in these childhood conflicts or with some significant element in her own personality or with a stereotype. For instance, she may identify the baby with "sex," or she may identify it with "aggression." She may then think of the baby as linked with sex, or as having something to do with aggression.

We had one clear case of this in a girl who had one daughter and was very worried when she became pregnant that she might have another. Whenever you find something like this, you should suspect unconscious conflict. We discovered that this girl had one sibling, a sister. She had been very jealous of this sister and very aggressive toward her during childhood. Now she was identifying herself with her present child and preparing to identify the baby with her sister. She was afraid that her older daughter would treat her younger daughter as she had treated her sister. About the seventh or eighth month of pregnancy, she suddenly began pouring out memories that had previously been suppressed, about how she and her sister had fought and fought to the death, about how she had hated her and felt she wanted to kill her, and so on. This kind of material, which, in a nonpregnant woman, you usually get only after 2 or 3 years of analysis, was coming into consciousness and being expressed very freely. At the same time the girl was terrified lest she give birth to a girl.

We worked very hard on this, trying to help her to see that it was not necessary for her to repeat, in regard to her children, what had happened in her childhood. It would have been interesting to

see how much we were able to accomplish. But unfortunately for science she gave birth to a boy.

I do not want to exaggerate the lack of anxiety with which this material comes out. I would say that the fact that it comes into consciousness at all is surprising. But there is some anxiety associated with it, with these memories from childhood. This attaches itself in a phobic manner to all kinds of things, and is probably the origin of the superstitions and fears of pregnancy that you find in practically every culture.

The woman may be frightened about her own health, or about the baby. She may be afraid that she will die during the birth, or give birth to a monster or a deformed baby, or that the baby will die. Many of these fears are linked with old guilts about masturbation, or with death wishes or other primitive emotions toward the mother or siblings.

The unconscious reasoning goes like this: "Because I did these naughty things in the past, I will suffer and my baby will suffer. Because I masturbated, my sexual apparatus was damaged, and I can never have a proper baby." This of course is tremendously important. Usually these thoughts remain unexpressed, because as soon as the woman starts talking about them, people say: "There, there. It's superstition. Forget it." Then, if she does happen to give birth to a baby with a congenital anomaly she says to herself, "This is what I expected. This is my punishment."

I once had a girl in analysis who illustrates this sadly. All through pregnancy she talked about how she was going to damage her child and give birth to a monster; how her child could not be any good. She wanted to breast feed, but she did not think her milk would be any good. She gave birth prematurely to a baby with multiple congenital anomalies, which soon died. When she came back into analysis, interestingly enough, she had forgotten all her fantasies during pregnancy. I very unkindly reminded her of these things, but she had not remembered them. She said, "I never believed in God, but now I do. I've been punished for all the things I've done." The baby being malformed was God's punishment for certain naughty things which she had done. Having this girl in analysis allowed me to uncover things that I am sure are very common in women who give birth to babies with congenital anomalies. Of course, if the anomaly is less serious, the reaction is somewhat less.

But during pregnancy women develop these fantasies. Then, if reality apparently confirms them, they are in a bad state. They find it difficult to perceive the baby and the situation realistically.

Work With Women During Prenatal Period

The change between the ego and the id is as if an iceberg had turned over. About 3 or 4 weeks post partum, the iceberg turns again, the unconscious material sinks back and the defenses are restored. It is an important and serious question, whether the iceberg takes down with it anything from our work with the woman during pregnancy. In other words, does intervention during pregnancy have any lasting effect after the pregnancy? Clinically, my impression is that it does, but we still have some research to do in order to be sure of that.

Take the case of my analytic patient, that we were just discussing. I had had her in analysis for about 2 years before she became pregnant, and knew her quite well. She was a girl with extremely strong defenses who could not bear to be in contact with any of her unconscious fantasies. We did not get very far in those 2 years. Then during pregnancy it began popping out, all the conflicts which I had imagined on the basis of the evidence were there. She began to talk very freely about her sexual difficulties, about all kinds of difficulties. From an analytic point of view this was a heyday. In 4 or 5 months we did much more work than we had done previously during a couple of years.

The question is, will this last? I can say that it appears to have lasted in this case. But whether that is due to the peculiar situation in analysis, where we were constantly working through the material, I do not know. Whether the same thing would obtain following anticipatory guidance in a prenatal clinic, I am not sure. But I think we have to hope for the best and try it and see.

The fact that pregnant women talk very easily about all kinds of material may be one of the things that scare off obstetricians and nurses. Just give these women a chance and the fantasies come pouring out. As far as the pregnant woman is concerned, her ego does not mind. But the listeners do mind; they are likely to get shocked by primitive material coming to the surface and withdraw.

If you put pregnant women in a group and give them a chance, all kinds of material comes out. An experienced worker could handle this quite easily. From a technical point of view, work with pregnant women is very easy. You do not have to mind your p's and q's. You can say all kinds of things that normally you would work up to gradually over a year or two, and even then approach gingerly because you do not want to destroy defenses too quickly. With a pregnant woman, you can talk to the point. The woman will bring up material about her mother, for example, and you can say: "O. K. So you hated your mother." Or she may tell you that when she was

a girl of 12 or 13 she masturbated, and you can talk quite openly about it.

If an insecure or partly trained worker were dealing with a case like this, the result on the worker might be rather disconcerting. If the worker became anxious this would have the effect of increasing the pregnant woman's anxiety. So this problem has to be looked at primarily from the point of view of the nurse who runs these parent classes for pregnant women, most of whom do not have too much training or too much capacity for self-awareness. I am not worried about the pregnant women, but I am worried about the worker.

Work With Husbands

Work with husbands is very important. I think that husbands who do not have an opportunity to play an active part during the pregnancy have a rather difficult situation. Many of them identify themselves with their wives. This is partly a rivalry situation because little boys have fantasies about having children just as little girls do.

Some cultures have what are called *couvade* traditions. Here, when the wife is in labor the husband goes to bed and the people of the village come and help him and deliver him. I think this is partly to cater to this identification of the man with the pregnancy, and partly to put him out of harm's way. That is, these cultures are reacting to their primitive awareness of the fact that a considerable amount of aggression is engendered in many husbands at the time their wives are giving birth. This is likely to show later when the new baby comes along and the husband feels that someone is pushing him out from the center of the stage. This is especially true with the first babies.

Usually the husband is not exposed to the kind of fantasies we were discussing earlier because pregnant women, due to their reality sense, do not usually talk about these to the uninitiated. They keep them to themselves, or talk about them to other pregnant women. But if they do let some of these things out, the husbands get quite disturbed.

Support for the husband during the pregnancy is important, not just for his own comfort or to keep the marriage off the rocks, though marriages very often do go on the rocks during pregnancy. It is also important from the point of view of the future father-child relationship. And also, if there is a disordered relationship between the husband and wife, especially around the end of the pregnancy, you tend to get a disordered mother-child relationship.

If the husband cannot charge his wife's battery so to speak, there may be difficulty. And he has to do this through love alone since sex is usually out of the question at this stage. The pregnant woman, at about the time of delivery and in that early relationship with the baby, is the channel through which the family caters to the child. As far as the child is concerned, the mothering person is the only important one. She is the one channel.

Since the child does not have a relationship to the mother as a whole person for 4 or 5 months, it does not matter whether or not this person is the actual mother. But it should be a single person, because smells are different, and feels are different. If a baby is to build up a satisfactory relationship to a whole object during these 4 or 5 months, the smell of the person and the sound of the person and the feel of the person should remain the same. If these are different, the baby becomes confused. But this need not be the mother; it can be a mother person.

In studying women who have a number of pregnancies you usually find that with each successive pregnancy different things come to the surface. And you also see a very interesting maturing process which takes place after the second birth. What this is due to, I do not know. It may have a physiological basis. In any case, after a woman has given birth to a second baby you get a sudden increase in maturity. She becomes better able to perceive reality and less influenced by internal fantasies, better able to occupy her role as an adult and not so overly dependent or underly dependent on other people. This affects her relationship to the second baby and also to the first baby. Whether this goes on progressively through successive pregnancies or not, I do not know. This is an area for further research. It would be interesting to know whether this is physiological or the result of a summation of emotional problems that have come up and been solved.

CHAPTER V

Origin and Development of Mother-Child Relationships

Now we are going to take up the signs of the developing relationship to the baby that arise during pregnancy and continue from there through the mother-child relationship during the first year of life. This will help us to appreciate the fact that, from the psychological point of view, pregnancy moves into motherhood without a dividing line. You should not think of pregnancy as one thing and motherhood as something else; one is simply a preparation for the other.

I would like to put before you the results of some work we have been doing in Boston over the past three years. We have been watching what happens during pregnancy, trying to trace out the origins and developments of the mother's relationship to the baby. The mother-child relationship has to start sometime, and somewhere; and it starts of course before the baby appears. If you want to go to its ultimate origin, it probably began when the pregnant woman was a child playing with her dolls, and identifying herself with her mother. But for practical purposes, we can see this relationship as originating during pregnancy. And the question is, can you learn something about the way the pregnant woman thinks, and from knowing how she thinks and feels about her baby, can you predict anything about the kind of relationship she is going to have to the baby? Can you identify different patterns of development in this relationship, and identify them in such a way that you can say whether in a particular case the development is going toward a healthy mother-child relationship or toward an unhealthy one? And if you can spot an undesirable type of development, can you do something to interrupt it during pregnancy, or prepare yourself to interrupt it as soon as possible after the baby has arrived?

I ask these questions, but I cannot answer them very clearly. A great deal of work still needs to be done here. But I can give you first impressions about some of our findings in this field.

We have found, among other things, that the psychological life of the pregnant woman, as seen in relation to the future mother-child relationship, divides fairly neatly into three categories, or sets of attitudes, which overlap to some extent but which can be differentiated. In the first place, there is a set of attitudes towards conception and pregnancy itself. Secondly, there is a set of developing relationships to the fetus, the baby *in utero*. And thirdly, there is a set of attitudes and relationships to her fantasy of the baby that is to be. Most pregnant women have these fantasies—daydreams, nightdreams, imaginations—about what their baby is going to be like. We shall now consider these different sets of attitudes in some detail.

Attitudes Toward Conception and Pregnancy

First we will consider attitudes toward conception and pregnancy. Here we immediately run into a myth which is widely believed among child guidance workers, to the effect that, if a woman rejects her pregnancy, if she is annoyed and upset when she becomes pregnant, something is basically wrong and such a woman is likely to have a disturbed relationship with her child. That is completely erroneous.

This myth grew out of findings based on a skewed sample; namely, that very tiny percentage of the population who attend child guidance clinics. Mothers bring disturbed children to such a clinic. The majority of mothers coming to a child guidance clinic have disturbed relationships with their children. When we asked them whether they wanted to become pregnant, 80 percent or so said they had not wanted to become pregnant and in fact had been very angry when they became pregnant. We therefore concluded, by a purely illogical process, that there was a high correlation between rejection of pregnancy and disturbed mother-child relationships. This is a type of error we make all the time.

When you work among ordinary mothers and children of the lower-middle and upper-lower economic strata, you find that 80 percent of these women reject the pregnancy when they first become pregnant. I mention the economic status because this may differ from class to class, but probably only 20 percent of young mothers in these classes want to become pregnant and are pleased when they do.

The usual reactions immediately after becoming pregnant are grief and anger and shame and some guilt. The reasons for this are many. There are economic hardships and thwarted ambitions for the woman herself or for her husband. This is especially true nowadays when it is very common for husbands who study to be

partially or almost entirely supported by their wives who work, so that if the wife becomes pregnant it may be a very serious blow to the husband's career. There are housing difficulties. And there are the intrapersonal difficulties of young women who have not yet matured and are not yet ready to have babies. Many young women would rather wait quite a time and get to know their husbands better, have a fling while they are young, and so on. It is also important that in the culture of this country, motherhood as such is not as highly valued as in some cultures; women here value other things. Ben Spock has a lot to say about the education of women in this country, and how this affects their ambitions in regard to becoming mothers.

Here I must remind you of a point that was made earlier. Pregnancy is not static, either from the physiological or from the emotional point of view. When you say 80 percent of these women reject the pregnancy, you have to specify just when they reject it. I have already specified that. It is when they first become pregnant.

If you follow these women, you find that, as a rule, within 2 months the vast majority of them have accepted the pregnancy and adapted to the situation. Probably by the end of the first trimester only 15 percent of them are still upset. And by the middle of the second trimester, after quickening, after the baby is felt, there are very few women in my experience who have not decided that they are glad they are pregnant. The fact is, that in the beginning of the pregnancy these women are not rejecting the baby, they are rejecting the pregnancy. They have no real thoughts about the baby; they are just pregnant. But when the baby starts kicking, when they begin to feel they are carrying a baby, many who have not yet adapted to the situation do so.

I am talking now about the first child. I have no figures for second children. I imagine the percentage would be less, but that might depend on how soon the second child came after the first. One would expect it would be less, because many of the reasons why a woman does not want a child are reasons for having no children. If this is out of the question it may not make much difference to her whether she has one child or two.

Women who want to have children and are trying to have children are pleased when they become pregnant, consciously at least. However, many women who cannot have children have rather mixed feelings. They try hard to have children, but unconsciously they may operate in the opposite direction.

Unconscious forces may also be at work in the opposite situation. Those women who do not want to become pregnant may unconsciously have a strong desire for a baby. The woman's nature,

as it were, cries out to have a baby, but she feels that she should not have one, because of social conditions and so on. These are the situations where you find some slip-up, actually a motivated mistake. The mistake is not always on the part of the wife. The husband agrees with the wife that she should not have a baby but, either consciously or unconsciously, he is opposed to this. So, either consciously or unconsciously, he makes a mistake. Afterwards he feels very guilty.

One often finds that husbands who have made their wives pregnant against the wife's opposition subsequently take over the maternal role. They get a baby from their wife and then proceed to mother the baby. They take over from the wife, who hands over the baby to them.

What I am saying applies to the usual married couple. I am not talking about out-of-wedlock pregnancies. That is another subject, on which I do not have much first-hand knowledge.

If we draw a graph of the attitudes these women have to pregnancy, 80 percent of them will begin with negative attitudes, which remain negative for 2 months or so, and then climb. The graph falls again in the last month. At this time the women get back some of their negative attitudes because of the physiological burden.

You find that about the thirty-sixth week to the fortieth week of pregnancy, the women begin to complain. They become depressed and complain that they are always wearing the same dresses, that they cannot run up and down stairs, and feel generally down in the dumps. These negative attitudes return, but it is important to realize that the negative attitude is toward pregnancy and not toward the baby.

Here I might say a word about nausea and vomiting. And again, we run into a very common fallacy. Many people, including obstetricians and psychiatrists, believe that nausea and vomiting are psychogenic. Why? Because the nausea and the vomiting occur in the first trimester, at a time when the majority of women are rejecting the pregnancy. So we put the two together and find that there is a high correlation. Add to this the fact that pregnant women frequently have the kind of fantasies we were discussing earlier and it is easy to conclude that the nausea and vomiting spring from primitive ideas of how one has babies. That is, the unconscious is supposed to believe that the baby is in the stomach, that it gets in through the mouth and probably passes out through the rectum, as little children sometimes believe. Vomiting is then seen as evidence that the woman is rejecting her pregnancy and trying to give up the baby. Such fantasies do exist, but in my opinion the ordinary nausea and vomiting of pregnancy is a physiological manifestation, somewhat like nocturnal enuresis.

Specialists in internal medicine are likely to say that children who wet the bed are problems for the psychiatrists. They cannot find anything physically wrong with them and therefore send them to the psychiatrists. But on examining them, the psychiatrists too find them pretty ordinary children. So the tide ebbs backward and forward between the psychiatrists and the pediatricians. I feel that nocturnal enuresis is, in the main, a physiological disturbance, which probably has something to do with hormonal balance and something to do with the secretions of the pituitary.

The same holds true for nausea and vomiting. This does not mean you cannot cure these things by psychological techniques, by suggestion or hypnosis. But the fact that you can cure something by hypnosis does not mean that it is psychogenic.

I am talking about ordinary vomiting, not about the pernicious type. This latter is very often a psychosomatic or hysterical disorder. But these cases are easy to recognize. Pregnant women who vomit themselves almost to death (sometimes actually to death if they are not treated adequately) have obviously disordered personalities with strong hysterical tendencies, and have usually reacted with gastrointestinal symptoms to other difficult situations in their life.

Attitudes Toward the Fetus

A woman's attitude toward pregnancy is certainly important. But it has very little effect on the future mother-child relationship. Her attitude toward the fetus is much more significant.

The fetus rarely becomes a reality to the pregnant woman until quickening. Before that she knows intellectually that she is carrying a fertilized egg, that it is developing, but it does not have real meaning for her. It becomes real when it first starts to move. Some women go clear through pregnancy without feeling that the fetus is real. This is a bad omen. The woman who goes right through pregnancy, knowing she is pregnant, but not feeling that it is real, is unlikely afterward when the baby comes to feel like a real mother to the child. Women show wide variation in their attitude toward the fetus. Here I am speaking statistically, of a large number of women, or of women in general. Any individual woman is likely to be fairly consistent in her attitude.

At one extreme you get women who very soon after quickening conceive of the fetus as a live person inside of them. They endow it with personality. They think of it quite clearly as a little boy, or a little girl; they often give the child a name while it is still *in utero*. They are very conscious of its movements, and ascribe feelings to it. They say: "Now it's getting excited," or "Now it's

going to sleep," or "Now it's waking up." They get real sensual pleasure out of these movements. They very often play with the fetus as one would with a child; they pat it, or stroke its head, and so on. They often involve their husbands in this play. Women who feel this way usually have intense feelings towards the fetus; they tell you: "I love him." This feeling of love grows as the pregnancy progresses.

Among women of this kind you usually find a special personality make-up. They are usually narcissistic women; women whose general personality is oriented to themselves. All this, within the normal range of course; I am not talking about abnormalities. But these women take an intense interest in their own bodies and their own personalities. This is the picture at one extreme.

At the other extreme, you have the women who never think of the fetus as a human being. They tell you: "Well, it's a fetus. It's a little organism there. I know what it's like and I know how big it is." They may even think of it as a depersonalized foreign body, like a tumor. Usually they have no feelings toward it. They say, "How can one feel anything toward this? Can you feel anything toward your stomach or your kidneys?" If they have any feelings toward it at all, they are likely to be negative feelings. I am not happy when I see this, because these negative feelings toward the fetus very often carry over to the baby.

These negative feelings are usually stimulated by the movements of the fetus. You find women who tell you: "This is a burden to me. I'm sitting reading the newspaper, and suddenly this thing gives a kick and the paper flies out of my hands," or, "It's pushing me out of bed," or "It's pushing my husband out of bed," or "I always used to lie on my tummy, and now I can't. This thing stops me from lying on my tummy," or "It keeps me awake at night with its kicking." Sometimes you can see even the father-child relationship being affected by the fetal movements. The father may be very annoyed with this baby that kicks him when he is in bed. "It's already causing trouble," he will tell you, "even before it's born."

Eventually the fetus becomes a living, breathing baby. But the woman does not necessarily make emotional contact with the child immediately after birth. There is usually a time lag of a few hours, a few days, or even a few weeks before she experiences a maternal feeling toward the infant. And if you ask women how long it was after birth that they developed full maternal feeling, most of them will be able to answer the question. A woman who has felt this knows what you are talking about. The feeling usually comes on suddenly. They describe it as a warm feeling, a feeling of protec-

tiveness and sympathy, a feeling: "This is my baby," with "my" underlined. Before it was just a baby, a nice enough baby, but "Now I feel suddenly that it's mine. I don't care what it looks like any more. It's my baby, and I love it."

The fact that this feeling is usually delayed is important for anticipatory guidance. Women who do not know this get frightened when they find themselves with a baby that they are expected to feed but have no real feeling about. It is important to tell a woman before delivery that this is likely to happen because if she expects it, she will feel more confident and secure. Moreover, when a worker predicts something and it happens, his prestige goes up. The early mother-child relationship can easily get off to a bad start if the woman feels alienated from her baby and uncomfortable because she does not realize that the maternal feeling will come, that in a few hours or a few days or in a few weeks everything will be all right. This alienated feeling, when not understood, can be especially damaging to a woman who is breast feeding.

Women of the narcissistic type usually have the shortest time lag. In fact their relationship to the child is usually a direct continuation of their relationship to the fetus, interrupted only by the birth process. The type of birth can make a difference. That is to say, if the woman has an anesthetic the process will be interrupted more than if she has a natural childbirth, where she actually or practically sees the baby coming out. These women, when asked how long it was before they had full maternal feeling, will say: "Well, as soon as I saw the baby. I love the baby now in the same way I've been loving him for the last 9 months. He's the same baby. It's just that now that I can see him, it feels a bit stronger." They will say, "When I look at him, it doesn't matter what he looks like. As far as I'm concerned, he's my baby, and I've been loving him for a long time." The actual perception of the baby doesn't seem to make much difference to them.

Women at the other extreme, who had no feeling for the fetus, when the baby does come have to build up a relationship with a stranger, and have a longer time lapse, other things being equal. With women of this kind, it is important how they perceive the baby, and how much contact they have with him. These women will tell you: "The maternal feeling came on when I bathed the baby for the first time," or "when I first put the baby to the breast," or "The second time I put the baby to the breast, I suddenly felt it." This is probably a rather primitive biological mechanism since the mother-child relationship in animals seems to depend upon certain perceptual cues.

Lorenz has called this "imprinting" and describes it very beautifully. His book⁶ opens with a description of a bearded professor crawling along in the grass by the side of a river. People passing by would see this peculiar man crawling around quack, quack, quacking; and if they got a bit closer they would see in the grass a lot of little geese running after him. The goslings were following him because he was their mother! Geese have different ways of quacking and if the professor quacked in the wrong language, say in black-geese language instead of white; the goslings got very upset and began running around in circles. In the case of these geese if, at a particular period after hatching, they perceive certain cues in shape, color, size, length above the ground, they develop an intense following response, which in our terms would be called a child-mother relationship toward this creature, whatever it is. If you present them with a wheelbarrow, the wheelbarrow will be their mother. If you present them with Professor Lorenz, he will be their mother. In the natural course of events, the mother goose will be their mother.

These experiments suggest that among human beings perceptual cues from child to mother and from mother to child may be of importance in building up these relationships if they are perceived at the appropriate time. And this brings us back to what we said earlier about the influence of the nipple and other part objects in building up the child-mother relationship. Obviously, human animals are much more complicated than the so-called lower animals, but as we go down the biological scale we can find the same things in more simplified form. For this reason, animal behavior can help us to understand the time lag we have been talking about. Apparently one must have time to see the other person, to perceive him, and to introject images which have become meaningful.

Attitudes and Fantasies About the Baby-to-Be

So much for the attitude to the fetus; now to the fantasies about the baby-to-be. Women who have intense feelings about the fetus, in the here-and-now situation, may also have fantasies about how things will be after the baby comes. These are likely to be a direct continuation of their relation to the fetus: "When my baby, this baby, Johnnie, comes out, this and this and this will happen; and I'm waiting for him to come out so I can actually see him." But women who do not have any kind of intense relationship to the fetus

⁶ Konrad Z. Lorenz: *King Solomon's Ring. New light on animal ways.* Tran. by Marjorie Kerr Wilson. New York: Crowell, 1952. 202 pp.

frequently have an even more intense fantasy life, in which they daydream all kinds of things about the baby.

The details of these daydreams are tremendously important in predicting the kind of mother-child relationship that is likely to develop. But women are apt to be shy about talking about these daydreams; they usually will not discuss them. However, it is not too difficult to elicit some details if the pregnant woman knows you.

There are various aspects of these fantasies which are significant. First, there is the age of the baby. Often women dream consistently about babies of a specific age. One can predict the best mother-child relationship from those women who tell you that they daydream about the baby as a little baby, about how they are nursing him at the breast or bathing him or dressing him or changing him, how they wheel him around, and so on. There is also an emotional coloring to daydreams, and an emotional coloring of warmth and love and affection also argues well for the future mother-child relationship.

There are, on the other hand, women who think only of older children. You find women who tell you; "I can't imagine the baby under 4 or 5 months old. Somehow I can't think of myself with a baby smaller than that." This is an important finding, because the woman who speaks in this way is likely to have special difficulty with the very small infant.

You are likely to find this type of reaction in somewhat hysterical personalities, women who cannot deal comfortably with instinctual things. This is understandable since for most people the small baby, the baby of up to about 3 months of age, symbolizes the instincts. Obviously it has no control; it is a very primitive creature. If we talk of it in terms of ego and id, it is a creature which is all id; there is no ego there. People who feel precarious in their control over their own instinctual life are likely to be frightened by this.

These things are shown in the daydreams, for example, by the absence of the young baby in the daydreams. If you ask these women a pointed question, they say: "Maybe sometimes I have a nightmare. I am supposed to be feeding the baby and I don't have any breasts, or out of my breast comes ink instead of milk" or something like that. You might be surprised at how many women do not think of a little baby at all, or even of a little child. They say: "I keep daydreaming about my child when he goes to college." If you ask about the courses he will take they tell you exactly what he is going to do. Or if it is a girl, she will be a dancer, and the woman will tell you, "I daydream about how she'll be dancing."

These daydreams lead you to suspect that the woman, even before the baby is born, is already preparing to use it in furtherance of her own ambitions. She is laying the seeds for a situation in which things which she could not do in her life, she is going to do via the baby. This again is something that one does not like to see. Such a woman is already reacting to the baby in relation to her own needs and not in relation to the baby's needs.

In these fantasies the sex of the baby is also important. Here the best sign, from the point of view of the future mother-child relationship, is indifference, the ability of the woman to say: "Sometimes it's a girl and sometimes it's a boy," or, "It doesn't seem to matter." When the fantasy child is always a boy or always a girl, you must ask questions. And you may find that this is related to some problems in the mother's own life. If the baby turns out to be the sex the woman wants, there is danger from these problems. And if it turns out to be the opposite sex, there is the danger of disappointment, or what is worse, the danger of a woman who tries to make a little boy into a girl or a little girl into a boy.

One can discover these things at this stage and prepare himself to follow through on a plan for taking care of this mother and child in such a way that the obstacles to a successful mother-child relationship are overcome or avoided.

I hope, in all that I have been saying, you yourselves have added: "cultural things being equal." I don't want to keep repeating this, but in considering individual forces one must always also take account of the culture.

One must ask questions not only about the woman's personal life, but also about her family and her culture. There is no doubt that the mother-child relationship may be disturbed by cultural forces. A culture which insists the child should be a boy creates difficulties for the mother when her child turns out to be a girl—which is slightly more than half the time.

Another thing to remember about these fantasies is that the mother who knows ahead of time exactly what the baby is going to be like, when the baby does come along may not be able to see him as he really is. In other words, the mother may "fall in love" or become infatuated with the baby of her fantasies, just as adults sometimes fall in love with fantasies. When that happens, one is not perceiving the other person at all, he is perceiving certain things about the other person, and on the basis of these perceptual cues fitting the other person into a preexisting image.

This infatuation period is very pleasant; falling in love is fine. The trouble is that a dependable interpersonal relationship cannot be built upon misperceptions of this order. In marriages

of this sort, people often fall out of love, which simply means perceiving the reality of the other person and finding that the reality doesn't in fact fit the perceptions you began with.

The same thing may happen to a mother and child. The mother may feel she has a "marvelous baby," because she is continuing the fantasy she developed during pregnancy. She may not then be able to perceive the real baby with his real needs. The healthy situation is that in which the mother is able to perceive the reality of the baby as another person, to respect that other person, and recognize that he has rights of his own.

This is something that pediatricians and nurses should be on the lookout for. When one finds a woman raving about her beautiful little baby just after he is born, and describing him in a way which does not fit in with anyone else's appraisal of what is going on, it is wise to remember the folk saying: "Love is blind;" and to remember also that in blind love the individual is not perceiving on the basis of reality cues, or only slightly so, but on the basis of intrapersonal fantasies which he is projecting onto the other person.

Influence of Woman's Personality Pattern Upon Emotional Changes of Pregnancy

The deprived woman

So far we have been talking about the general aspects of pregnancy, but there are one or two special patterns I would like to call to your attention. First, there is the deprived woman.

A woman who did not get an adequate amount of love and affection and support in her childhood goes through life hungry, unsatisfied, always feeling that fate is against her, that bad things always happen to her, that she never gets the good things in life. When such a woman becomes pregnant she presents a special problem, which is familiar to all people who work in prenatal clinics. She tells herself: "Now I'm carrying a baby inside me, and all these people are interested in the baby. They're not interested in me. They are coming and taking things out of my diet and paying attention to what's inside me, and they don't care about me at all." Such women often make tremendous nuisances of themselves in not carrying out medical orders, and especially in fighting the nutritionists.

We have worked out certain principles in our clinic in Boston, for dealing with these women, which seem to work very well. Some

of our most successful cases, the ones we are proudest of, have been with this type of woman. The important thing here is to recognize that the woman has unsatisfied needs, that you must give to this woman and give and give all the way through pregnancy, and afterwards.

You might be surprised at some of the things we do. We rarely talk about the baby with such a woman. We talk about *her*. If we talk about the baby, it is merely as someone who will supplement her.

In regard to food, we never take anything away from the woman. The nutritionist gives her a diet and stresses the things that she is adding to her meals. We do not talk to the woman about layettes. We do not talk about preparations for the baby, except little by little as she develops a relationship with us and becomes secure in the knowledge that we are interested in her.

If you visit such a woman after the baby is born, it is a mistake to ask to see the baby. Very often she will not show you the baby. It is difficult for a worker to go into a home and not ask to see the baby, but if you do this you go down several steps in the woman's esteem. She is very interested in whether you are interested in the baby or in her.

With women of this kind it is especially important to work with the husband. But you must not see the husband alone or the woman will feel the husband is getting more interest than she is. So we have worked out techniques for joint interviews, in which we say to the husband what we want the woman to hear. We tell him the things we want to communicate to her. At the same time, we tell him how important it is for her to rest, to have special love and attention and so on, all of which makes her feel much more confident. These small devices make all the difference in how this woman is going to accept her baby afterwards. By observing them one is able to accomplish something definitely concrete and constructive.

The hysterical personality

Another type of woman that needs special comment is the hysterical personality. Girls who have had trouble in their sexual development, who at 4 or 6 years of age have had difficulty in their relationships with their mother or father, are very often narcissistic. As you would expect, when you get this iceberg-turning-over phenomenon, during pregnancy, such women may bring up quite a lot of material. They usually have an excessive amount of free-floating

anxiety, especially at the beginning of pregnancy, and a tremendous number of phobias.

Very often the gross hysterical symptoms you see in the beginning of pregnancy die down toward the end. The obstetrician is likely to feel: "Well, look. She's cured. She's no problem at all." When the mother is a nice looking young hysteric, a young obstetrician is especially likely to feel that this is a very nice situation. Here is an intelligent, beautiful, nice girl, and everything in the garden is lovely. The hysterical symptoms die down at this time because the normal physical manifestations of pregnancy act in place of conversion symptoms. The girl trades in her conversion symptoms for normally occurring features of pregnancy, and the symptoms come back after the baby is born.

In the fantasies of such girls, you often find a fear of the young infant. This is because the girls are afraid of their instincts. You also find girls who are afraid to breast feed because they think it would be shameful if someone came into the room and found them doing this. They sexualize everything, including breast feeding. The breast in a woman who is not a mother is an erotic part of the body, part of the sexual apparatus. But when the woman becomes a mother and feeds her baby, a change takes place; the breast is de-eroticized. That is why girls who normally are not very brazen will breast feed their baby in company without much difficulty. And if they do not, it is not because they feel ashamed, but because they are afraid other people will feel uncomfortable. In fact, when the breast becomes a maternal apparatus it ceases to be an erotic organ.

Now with the hysteric this change does not take place. Since her sex life is loaded with guilt such a woman gets a guilty and shameful feeling in feeding the baby. So if you persuade such a woman to breast feed, you may run into serious difficulties.

Treating the hysterical girl during pregnancy consists largely in trying to desexualize the whole business of childbirth and children. This is done by strengthening any other defense she may have. Hysterical girls are often romantic, and this romanticism is a desexualization. Naturally, I do not mean that all romantic love is hysterical; it is often a cultural phenomenon. But in the case of the hysterical girl, we can help her to romanticize the pregnancy and the birth process and the taking care of the baby. We can talk to her about how marvelous it all is, how marvelous nature is. We should not spend much time talking about her phobias. If we show her pictures they should be diagrams and not real pictures. That is, we may show her diagrams revealing the wonders of nature, but not crude pictures of bodily organs.

The obsessional personality

There is one more type I would like to mention very briefly. These are the obsessional personalities, girls who are always very tidy and neat and orderly, and who feel that time is very important. They may have various obsessional symptoms. Usually they have a quiet time during pregnancy, for reasons which I do not want to go into now. They ask a tremendous number of questions, because everything has to be settled and tied up for them. They're especially likely to worry about what will happen during birth. I think that all pregnant women should have detailed knowledge about what is going to happen during the birth process. But this is especially important for these obsessional women. We will come back to this subject later.

Nutritional Problems During Pregnancy

Since I have been working at Harvard with Mrs. Burke,⁷ who has done so much pioneer work in the field of nutrition during pregnancy and shown the importance of adequate diet for the physical welfare of the pregnant woman and her baby, it is only natural that I should be interested in nutrition. But there is also another reason for this. The nutritionist is the person on the team who discovers the emotionally disturbed women most quickly. This is because disturbed women have almost always had disturbed relationships with their mothers during childhood. Even though they may not remember it, they have usually, as children, had feeding battles with their mothers. They form a very rapid transference relationship with their nutritionist because the nutritionist deals with food as their mothers did. They transfer their old feelings for their mothers onto the nutritionist, and proceed to have feeding battles with her. It is especially when she tries to get them to drink milk that the battle starts.

We try to get around this by dissipating the stereotype, the terrible stereotype of the nutritionist-mother. Sometimes we get the obstetrician to prescribe the diet. In this case we are letting the nutritionist continue to be the bad mother while the good father gives the food. There is another technique, which is more appealing to nutritionists, which is to try to break the stereotype by turning the dietary advice into a medical prescription. Here the nutritionist talks about proteins and carbohydrates and milligrams and calcium and such things, and gives a prescription, which is then backed up

⁷ B. S. Burke and H. L. Stuart: Nutritional requirements during pregnancy and lactation. *Journal of American Medical Association*. 1948. 137, 119-128.

by the obstetrician with the weight of his medical prestige. In this case, the woman will continue to have whatever problems she did have with her mother, but she will stop working them out on the nutritionist. This is an important accomplishment. Pregnant women, because of various metabolic and psychological changes, and especially because of their increased introversion and oral receptivity, will, if you leave them alone, eat too much, and this increases the danger of toxemia. So the nutritionist often has to say, "Cut down." This is one of the most difficult things in the management of pregnant women, from the obstetric point of view. And here the social worker or psychologist can be of great help, by discovering the issues actually involved so that other members of the team can steer around them. These are essentially issues that have to be sidestepped in order to deal with other, pressing, matters.

Emotional Aspects of Labor and Delivery

There seems to be some evidence that emotional difficulties during pregnancy correlate with difficulties during labor. The evidence for this is rather skimpy, so far as my own experience is concerned. I think this is another area in which a great deal remains to be done. There is little doubt, however, that a woman who has been given anticipatory guidance on labor and delivery has an easier time. That is just common sense.

At this point I would like to say a few things about natural childbirth. This is a recent fad and like all fads, has probably more bad in it than good. To be sure, if a woman knows what is going to happen before she goes into labor she will feel more comfortable. No one denies this. But natural childbirth attracts a great many women with hysterical personalities, who do not have any pain at all because of the suggestive aspects of the hypnotic management. It also attracts a number of obstetricians who feel that in this way they are doing something about the psychological aspects of patient management. But places where natural childbirth is practiced can be just as stereotyped and the personnel have just as little insight into the individuality of the patients as places where these principles are not subscribed to.

Obstetricians seem to think that any psychiatrist who is interested in the emotional aspects of pregnancy must automatically be in favor of natural childbirth. It surprises some of them to find that some of us are not. I understand that a long anesthetic has some physical effect upon the baby, which I am not competent to discuss but obstetricians are. Also, the longer the break at this time the longer the time lag, but I am not convinced this necessarily has any

evil effects. However, I would say that, other things being equal, it is probably a good idea to give as little anesthetic as possible so that a woman can make contact with her baby as soon as possible after birth.

Some 2 or 3 years ago, I was investigating the thoughts of women during labor. I thought that labor would be a good time in which to get all sorts of fantasies about the baby, approaching motherhood, and so on. I sat with a number of women in labor and discovered to my surprise that they were not the least interested in the baby at that particular time, that practically all of them had their attention firmly fixed upon themselves and upon getting this labor over with and the baby out. Even though the baby had been a person to them all during their pregnancy, when they went into labor their attention turned away from it completely and focused upon themselves. Apparently some kind of psychological curtain descends at that particular stage, and the mother's thoughts do not follow Johnnie through the cervix and down the birth canal. Women who have been indoctrinated by natural childbirth teachings may feel differently, but this self-centeredness appears to be the natural way for women to react during childbirth.

I hope I have not offended you by these rather rude remarks about natural childbirth, but I think on the whole this movement does a disservice to the cause of healthy mother-child relationship. In the first place, it is so obviously a fad. It is so obviously a package deal, and so obviously lends itself to stereotypes. And it also gives a handle to obstetricians who know very little about psychiatry and dismiss other kinds of service by saying: "That's just more of the same nonsense." Naturally, I think this is a disservice!

On the other hand, there is no doubt natural childbirth teaching does a lot of good in some places, because after all, even though the theoretical framework is questionable, where these procedures are in effect some attention is paid to the feelings of the woman. In an institution which practices natural childbirth, there will at least be people who talk to the woman beforehand about labor, and that is certainly better than nothing.

Anticipatory Guidance

The advisability of giving detailed anticipatory guidance about labor depends upon how it is given. For instance, if a hysterical woman were given anticipatory guidance with lurid details and pictures which are actual transverse sections of living bodies and impress upon her the carnal aspects of the process, I think the

effect would be quite the opposite of what we want. As a rule, however, the natural childbirth people manage to romanticize the whole thing. This is an ideal technique for hysterics. You will find hysterical women who tell you it was the greatest experience of their lives. They will describe it as an orgasm, but an orgasm culturally permitted. That is because the process has been romanticized and sentimentalized. Where this is successful, it is good management.

If you deal with women in groups, the pictures shown should be diagrams. Diagrams are reasonably innocuous. However, no matter what you do in a group situation, you will do some harm to some individual. In planning for work with groups, you should always make plans for picking out members who are disturbed, and then for picking them up afterwards. One reason why a group should be kept small, is that this makes it easier to see who is disturbed and to pick up the pieces. But one should not worry too much about these things. After all, the pregnant woman we are talking about has contact with a nurse or a social worker and she is going to hear much more lurid things from her friends and neighbors.

There is one more thing I want to mention before we leave the psychological aspect of labor, and that is the relative amnesia which sets in between 3 and 6 weeks after delivery. If you ask a woman 6 weeks after delivery, you will find that she has forgotten practically all of these emotional manifestations I have been talking about. You have a very rapid forgetting here.

Pregnancy in Relation to History of Previous Disease

I have very little personal experience with this, though at the moment I am part of a research project concerned with Rh Negative blood. The question here is, if a woman has Rh Negative blood and her husband Rh Positive, with some slight danger of Rh sensitization, does this complicate the pregnancy? I do not want to prejudge the result of this investigation. Naturally, the situation is very serious whenever there is sensitization and danger to the life of the newborn. But apart from such cases, it is possible that the presence of these cues to anxiety may stimulate and exaggerate preexisting anxieties. That is, the woman spends a great deal of time thinking that the child will not be all right, or that she will not be able to deal with the child, or feeling ineffectual in herself as a woman. If not handled, such fantasies might produce certain tensions in the mother-child relationship. It is not support that

such a woman would need. Rather, she would need opportunity for ventilating her fears.

Influence of Marital Relationships on Attitudes Toward Fetus

The woman who is happily married, who is satisfied with her husband, is more likely to have an undisturbed maternal relationship to her child than the woman who is unsatisfied with her husband or subjected to certain other pressures in her family circle. This follows from everything we have been saying.

Influence of the Culture

We know that different cultures have different ways of dealing with pregnancy. Probably many of the things which we have said are necessary, such for instance as that a husband should charge his wife's battery by giving extra love and affection during pregnancy, are necessary in our culture, but not in others whose traditions act as an emotional nest for the pregnant woman. That is, a woman might not need these individual ways of relating, if the group as a whole was dealing with her in a certain way. Each culture has to be studied individually in order to see how the characteristic traditions of that group influence the picture.

I do not believe that the mood swings of pregnancy are culturally based. Perhaps the ways the women talk about them are, but not the changes themselves. However, the increased introversion and passivity may, and the attitude to the fetus and baby-to-be most certainly does, differ from one culture to another. Some cultures prescribe how a woman should think about her pregnancy and her baby, and every ordinary member of the culture reacts in the expected way. In many cultures details of the interpersonal relationships are formalized. The relation between you and your father or mother or sister or brother is laid down exactly. Such cultures do not have the individual variation and consequent possibility of conflict, tension, and difficulty which are found in ours.

We must be aware, not only of different cultures, but also of different subcultures. One of the problems in a prenatal clinic is to make sure you do not set up too many tensions between the culture of the clinic and the culture of the individual with whom you are dealing.

Let us take nutrition for instance. I think many of you know Pauline Stitt. She is especially adept at getting to know the cul-

tural traditions of the women she works with and incorporating these in her pediatric advice. That is, she is able to give advice, in regard to feeding for example, which does not conflict too greatly with the traditional modes of eating in a particular culture. If she is going to advise an Italian woman, she will first learn something about Italian foods. She will choose the right kind of nutrients but in the Italian style. She will not prescribe some patent baby food, since she knows that if she does, even if the woman believes her and intends to follow her advice, the woman's mother is going to say, "That's a lot of nonsense."

In order to do our work well, we must have certain special information about the culture of the person with whom we are dealing. This means that we must have access to information on Italian, Hawaiian, Irish, Negro, and possibly other cultures. It is the social worker who can be expected to have this knowledge and pass it on to the other members of the team.

Another factor which varies from culture to culture is the role of the grandmother. I have been impressed by the role of the grandmother among the Negroes, especially among the southern Negroes I have seen who have migrated up to the Boston area. Among these people, the mother of the young mother, or the mother-in-law for that matter, is the one primarily concerned with the upbringing of the child. It is accepted among them that a young girl, having a baby at the age of 16 or 17, does not do the real mothering. Her mother or mother-in-law takes over and she and her baby probably have a kind of sibling relationship for some time. Later, when she has had a few more children, she assumes the mother role. This is perfectly satisfactory, provided the people working in the clinic understand it. But you get into difficulty when the girl has imbibed some of the New England culture, say, or has been indoctrinated by the people in the well-baby clinic, and feels she has to act the mother. To do this, she will have to fight with her own mother or mother-in-law.

There are many cultures in which the grandmother has this role. It is known that biologically girls can give birth at a very early age, but nobody expects an immature girl to carry the responsibilities of a mother. She must act as an apprentice until she gets older. She helps her mother and learns how her mother does it. Eventually, she acts as the mother to her grandchildren. This is perfectly all right, although it involves a rather complicated development in the object relationships. The first "mother" here is not the mother at all, but the grandmother, unless the mother is breast feeding, in which case you have a complicated split.

I have made some studies of children brought up in communal settlements in Israel, where from birth the child is removed from his parents and taken care of by professional workers in baby houses. The mother comes in to breast feed, but the various mothering activities are carried out by these professionals. The mother and father visit during the day for 2 or 3 hours. This brings about special patterns of personality development, but as far as we can determine, the basic principles we are talking about continue to hold. And the special personality development which is produced is in keeping with the expected environment in that culture, as of course happens everywhere.

Effect of Attempted Abortion

We all know that there are women who, for one reason or another, reject a pregnancy to such an extent that they try to terminate it. In other words, they try to abort. Studies show that this is a very important fact, which one must always be on the lookout for.

Sometimes women who do not get on well with their husbands have a baby in order to patch up the marriage. This is a very dangerous situation for the future parent-child relationships. When the marriage is on the rocks and either the husband or the wife decides to have a baby in order to cement the marriage, the baby is already, even before conception, being used vicariously to solve someone else's problem, and the likelihood of a disturbed parent-child relationship is very great. But situations like this are not as common as some people think. More often, where there is marital disharmony, you get an intense rejection of pregnancy, which may reach the stage of wanting to destroy one already begun. There are other reasons, too, for women wanting to abort. During the first months of pregnancy when the woman is likely to be upset, the husband may get upset too, and the idea may occur to them to abort.

Now if a woman attempts to abort and fails and the pregnancy continues, and if she belongs to a culture which is opposed to abortion, there is a very great likelihood that a particularly pathogenic type of mother-child relationship disturbance will follow. I have studied a number of cases and can specify with some exactness the type of disturbed mother-child relationship which ensues when you have a failed abortion in a woman who belongs to a culture which is opposed to abortion. In most cases this leads to a disturbed personality development in the child which, in turn, produces a child of a very special personality. This is tremendously important because it presents us with a discrete situation in which

it is possible to do adequate preventive work. If we can alert public health nurses, pediatricians, obstetricians, and others, to the particular danger of failed attempts at abortion, we can enable them to prescribe some very potent mental health first aid.

I have said specifically, "in a culture opposed to abortion" because, under these circumstances, the woman feels she has committed a crime or a sin. Usually there are religious restrictions to abortion as well as legal ones. The woman keeps the act a guilty secret, keeps the guilt within her. She feels that she has attempted to murder her child and is afraid that she has done it some harm. After the child is born she takes him from doctor to doctor, from clinic to clinic, saying, "Isn't there something wrong with the child?" When she is told no, that there isn't anything wrong, she will ask, "Isn't there something wrong with his head?" and when told there is not, "Isn't there something wrong with his ears?" or "Isn't there something wrong with his fingers?" She keeps trying to persuade the pediatricians to find something wrong with the baby. Why? Because if they do, she will have something concrete to worry about and this will relieve her. This is one manifestation of guilt.

Guilt may be manifested in other ways. The woman may feel that the baby is part of herself, a bad thing which has come out of herself. She feels that she has done a bad thing, and the baby is a symbol of it. You sometimes find very gentle women suddenly attacking their baby. At that moment they are really punishing themselves. This baby is partly punishment and partly a scapegoat on which the woman works out her feelings of guilt, hitting herself by hitting the baby.

More often such a woman wraps her baby in cotton wool, but in a destructive kind of cotton wool. You see these children coming to child guidance clinics. They are all weakly. They look like a set of siblings, because they have all been brought up in this same kind of relationship.

We made a study of this problem in Jerusalem. It is very simple to make a cross-cultural study there, because in 20 cases you are likely to have 15 different cultures; you don't have to look for them, they are just there. We found that it is only when the culture is opposed to abortion that you get this situation. In a culture that does not consider abortion a terrible thing, the woman may attempt to abort and fail, without any psychological damage.

In the cases we are discussing here, as soon as possible after a woman has attempted to abort and failed, one must try to lower the pathological guilt. This does not mean that you tell her abortion is a nice thing; that would make her feel that you are a bad person, too. What we want to do is lower the feeling of guilt to a normal

level. She should feel guilty according to her culture or religion, but she should not have these tremendous feelings of guilt which are going to distort her relationship with her child. It is relatively simple to bring this down to a normal level, especially as the majority of these women are not pathological personalities. You do this by establishing an ordinary kind of relationship with the woman, and then giving her an opportunity to talk about what she has done, letting her realize that you do not feel she is a monster for having done it. This is work which an obstetrician or pediatrician or nurse can very easily be trained to do, assuming they are not too upset by their own cultural attitudes to behave in this manner. It is my experience that most people are able to separate their personal religious feelings from their professional role and to conduct this simple bit of mental health first aid.

This does not work, of course, in all cases. Where the woman has a disorder of personality to begin with, the nurse may find that her first aid does not work. In that case the woman should be referred to a specialist.

A woman who attempts to abort by taking drugs or by mechanical methods, may, in fact, injure her fetus; she may produce congenital anomalies or Mongolism or some other type of damage. Under these circumstances, you have a very difficult therapeutic problem. I regard this as a psychiatric emergency, just as urgent as an acute appendix. If you do not deal with this as an emergency immediately, and with all the skill your local staff can provide, you will have serious trouble afterwards. The woman will be unable to cooperate in any kind of reality-based assessment of the situation or to cooperate with her medical advisors in planning for the welfare of the child. All we want is to enable the woman to work through her guilt, and people can work through guilt in regard to reality matters amazingly well. What they cannot work through is guilt in regard to fantasies that are unconscious. You cannot deal with them if you cannot bring them into circulation. But in my experience, it is always possible to deal with a reality situation, no matter how difficult it may be.

CHAPTER VI

Mother-Child Relationships During the First Year of Life

We are now going to consider what happens in the mother-child relationship after the baby is born. We will limit our discussion to the first year of life because we have to stop somewhere, and a consideration of the mother-child relationship during the first year will give us some basic principles which can be extrapolated for the relationship later on. And I am going to divide the first year into three parts, distinguished by the stimuli which come to the mother from the baby.

The Primordial Period

The first period is that of the first 2 to 3 months, in which the baby is perceived by the mother as simply a bundle of instincts, completely helpless, completely dependent. He has no "personality."

Many mothers are affected in a desirable manner by contact with such a helpless mite. It evokes in them an outpouring of maternal feeling, or protectiveness. But others are upset by this, and for various reasons. Some are afraid of what they may do to this helpless little thing. These women think of the newborn infant as a sort of fragile doll. They are afraid they are going to break it. They handle it very, very gingerly. They are afraid of its neck bending or breaking, or they are afraid of snapping its arms or its legs. They are especially afraid when they have to give the baby a bath. By and large these are women who have had very little experience with children. Among those will be some women who have difficulty in dealing with their aggressive impulses. Here we approach the pathological, which I do not want to discuss. I am thinking of obsessional personalities, women who have considerable difficulty with their aggressive impulses and never quite feel confident that they are going to be able to control themselves. Presented with this helpless, defenseless, little thing, they are afraid that they are going to do it some harm.

There is another group of women who are frightened in a very different way. They are frightened because this bundle of instincts seems to them so wild and uncontrolled. The first group is afraid of what they will do and the second group is afraid of the baby. You actually find grownup women who are afraid of this little thing and treat it as if it were some kind of savage animal.

Now, the most significant thing in this period is that the mother gets no recognition from the baby for what she does. During this period, the baby does not give any thanks to the mother for her ministrations, and you know how eager mothers are for the first sign of thanks from the baby, the first smile. Many mothers are very interested in the baby's first smile, because, for the mothers, the smile says: "You are a good mother. I like you. I'm smiling at you." This does not take place for 2 or 3 months as a rule, and it requires a certain amount of security on the part of the woman to continue to mother the baby and never get anything in return.

During this period, the mother and the child can hardly be thought of as two separate individuals. Surely, the umbilical cord is cut at the moment of birth or shortly afterwards, but from a psychological point of view, with many women there is still no separation of the baby as an individual. We can call this kind of relationship symbiosis, and talk about the symbiotic unity of the mother and child.

There is a very important book, called *Nursing Couple*⁸ by Middlemore, which I would like to recommend to you. It is a delightful report of a study carried out by a child analyst, in London, who sat at the bedside of some 50 nursing mothers in one of the hospitals in London, and observed the mother-child behavior. She then observed the behavior of the newborn infants in the nursery, and divided these into various groups, according to how they sucked. She classified them as satisfied sucklings, dissatisfied sucklings, passive-dissatisfied, active-dissatisfied—a whole list of divisions which do not concern us here, except for the fact that it is possible right from birth to see these constitutional differences.

Middlemore uses the term, "The Nursing Couple," and points out that at first, especially if the woman breast feeds, there is a unity of mother and child which must be constantly borne in mind.

Remembering what was said earlier about the mothers' reactions to the fetus, we would expect that women of the narcissistic type would be more likely to show this symbiotic unity with their baby than women at the other end of the scale. And this is, in fact, the case. Narcissistic women are closest to their babies during preg-

⁸ Merrell P. Middlemore: *Nursing Couple*. London: Hamilton, 1941. 195 pp.

nancy and also after the babies are born, because, so far as they are concerned, the baby is still a part of their own body. It is very nice to watch such a woman breast feeding. She has great sensitivity to the needs of the baby, and it is interesting to see the gentle, warm way in which she handles it, as though it were still an extension of herself, as though the umbilical cord had not yet been cut. You do not get such obvious unity in women of the opposite type. Nor do you notice it where there is the maternal time lag, since here the mother and child are two separate individuals immediately after birth.

It is very important to realize that this symbiotic stage must come to an end, that in order to get an adequate mother-child relationship, there must be a psychological separation of the mother from the child. We will talk later about the evils that may follow when mother-child separation is too prolonged or not at the right time and place, but we must realize that, from the psychological point of view, this separation is an essential stage in the growth process. Unless the mother is able to separate herself from the baby, to cut the psychological umbilical cord that binds them together, and move out of this symbiotic relationship, you get one of the worst types of disturbed mother-child relationships it is possible to have. Unless this takes place, the mother will be unable to perceive the child as a separate person, because to her it is not a separate person, it is part of her psychological body. She feels she knows what it wants. And she does know what it wants as long as it is 1, 2, or 3 months old. But when the child gets beyond that stage, it begins to have a life of its own and the mother no longer knows what it wants.

So this symbiosis, this unity of mother and child, is fine for a while. One can feel very happy about it at the beginning of the mother-child relationship. It helps in the initiation of a satisfactory breast-feeding relationship. But it is a stage of growth and must be outgrown.

If one wanted a single expression for the most satisfactory development of the mother-child relationship, I would recommend one put forward by Winnicott, a child analyst of England, as a title in a very beautiful book which he wrote for mothers and children, "Getting to Know Your Baby."⁹ This is one of the most beautiful pieces of work I know. You feel that the analyst knows how mothers feel and what mothers think. He talks to them in their language, and the thoughts coming off the printed page seem to really belong to them.

⁹ Donald W. Winnicott: *Mother and Child*. A primer of first relationships. New York: Basic Books, 1957. 210 pp.

Before a woman can get to know her baby, the baby must be a separate individual whom she needs to know. This requires psychological separation. I would say that what you are primarily watching for in a mother-child relationship during the first year, is to see that this process of psychological separation takes place adequately. Only then can the mother realize that the child is a new individual, a dependent but separate human being. Mothers who start off without this symbiotic unity have a certain advantage in this respect. They are already separated. But here again we are dealing with a balance, because there are some women who are too separate, too distant from their babies. We will return to this later. But the aim of the pediatrician, the nurse, and other care-taking agents, should be to insure an optimum distance between the mother and the child, not too great and not too small.

During these first 2 or 3 months, the mother-child relationship is very much influenced by the relation between the activity type of the baby and the needs and expectations of the mother. Obviously the way you handle an active baby is different from the way you handle a passive baby, and the way you handle an irritable baby is different from the way you handle a somnolent baby. Some women are so geared, as a result of their expectations during pregnancy or of something else, that they need an active baby. If then the baby turns out not to be active at all, but to be a somnolent baby, there will have to be a period of adaptation between the mother and the child. This can be quite complicated. Care-taking agents can do an important job here in helping to support the woman until she is able to rub shoulders with this baby, as it were, to perceive what the reality is and fit it into her previous expectations.

The Latent Period

The second period, which lasts from about the second or third month up to about the seventh or eighth, might be called the latent period. It is a peaceful period. The baby begins to be a person, he begins to give thanks, but he is still completely dependent. He is not rebellious in any way. Wherever you put him, there he lies. There is very little trouble in this period, unless difficulties which developed during the first period carry over. Any initial feeding difficulties or nursing difficulties have been dealt with. At this stage the baby feeds all right and usually sleeps a lot of the day.

This is the height of the sucking stage, when a good deal of the baby's attention is focused on sucking. As long as the mother is able to satisfy this, the baby is happy. Moreover, the baby has already begun to smile. He gurgles and coos and makes the kind

of noises mothers like to hear. When the mother does something for the baby during this stage there is no doubt in her mind that the baby likes it.

The danger during this period is that the mother may get the feeling that this is a perfect baby—"my wonderful baby." She is in for a disappointment towards the end of this period unless she realizes that the baby is not going to be like this always. Here is a place for anticipatory guidance. The woman should be told that things are going to be different. Toward the end of this period, the baby moves from the sucking stage to the biting stage. He becomes an obviously more independent individual, not so completely at the beck and call of the mother. If the woman has been getting considerable satisfaction, as most women do, from this situation, she may feel frustrated and become angry with the baby, because it appears to be developing naughty habits. Most women do not find anything nasty about the excreta of babies, but as you get toward the end of this period the stools begin to have odors and consistencies which women feel are more obviously dirty. Altogether you get into a rather troubled area. Things are not as smooth and peaceful as they were.

The Relinquishing Period

From the seventh or eighth month up to the age of one year, the baby begins to stand on its own, even literally, and has an increased aggressiveness. It is beginning to have control over its own bowel action. That is to say, it can now willfully make a mess, whereas before the mother could, if she wanted to, establish some kind of potting reflex. Some mothers do this and get very few dirty diapers. Or they find that there is some natural rhythm and adjust themselves to this. But as you get toward the end of the first year, these useful routines disappear and the baby becomes unpredictable.

If the mother is prepared for this, there should be no great difficulty. But she must be prepared for a progressive psychological separation. If there has been a symbiotic love earlier, it must now change. If it does not, we have a very dangerous situation. In fact, psychosis in childhood is often associated with a symbiotic unity of mother and child which was never dissipated. There are other causes for psychoses, to be sure, but this is one cause. It is essential that the type of love which the mother has for the child should change from something which we have called symbiotic to another type which we might call anaclitic. "Anaclitic" means "leaning against." By anaclitic love I mean the love of two separate people, one leaning against the other. I mean, of course, the child leaning against the mother, and not the other way around!

During this third period, there are several dangers. One is the danger of wanting to keep the child a baby, a perfect baby, for longer than he can take it. Another is the danger of trying to hasten the baby's independence, of pushing him faster than he is naturally developing. You will find women who vie with their neighbors in the speed with which their children develop. Such women compare notes as to whose baby stood up soonest, or talked soonest, or did this or that or the other soonest. They tend to push their children, purely for social reasons, faster than the child can go.

A third danger lies in the fact that the mother is now, for the first time, faced with the need to control the baby's activities. Here she encounters her first problems in striking a balance between flexibility and limit setting. During this first year big changes are taking place for the baby. Changes are also taking place for the mother, which are equally big though less obvious.

Quite a bit of adaptive responsiveness is needed on the part of the mother in this matter of imposing limits, especially with a first baby. The function of the care-taking people should be to support her, to help her to feel secure enough to move from stage to stage, and to smooth the path for her by letting her know what to expect. At this stage the family atmosphere is also very important. If the mother has the support of her husband and other members of her family she will be operating on a more stable basis as she makes these changes.

Developing Mother-Child Relationships

Psychological separation of mother from child

The kind of care needed by the narcissistic type of woman is very different from that needed by women at the opposite end of the scale. Narcissistic women who have strong symbiotic relationships with their newborn infants are likely, later, to be overpossessive mothers, who use the baby for their own purposes. The narcissistic girl may spend a good deal of time dressing the baby up, making him lovely. There is certainly no harm having the baby look lovely, but one must make sure that the girl is not using the baby to show herself off.

David Levy¹⁰ has given us a nice device for testing this. If you are sitting talking with the mother and she is holding her baby, and you say, "Mrs. Jones, you have a lovely baby there," there are two typical reactions. The woman who regards her baby as a separate

¹⁰ David M. Levy: Psychosomatic studies of some aspects of maternal behavior. *Psychosomatic Medicine*, 1942. 4, 223-227 (April)

individual will look at the baby and give a little smile and say, "Oh, well, thank you very much." The woman for whom the baby is part of herself will not look at the baby at all, but will look at you and say. "Oh, thank you very much." She takes the compliment for herself. In that quick little exchange, watching the way her eyes go, you can learn what the relationship really is.

When you know that you have a mother of this kind you must work in the well-baby clinic to increase the distance between her and the child. Wilma Lloyd¹¹ has written a paper about group work with mothers and children which shows very clearly how one does this. To begin with, you lend the woman your eyes and ears; you get her to identify herself with you as you look at the baby. Wilma Lloyd describes her nursery school with the children playing and climbing up and down, and tells how she would gather the mothers around her and say, "Now, look. There's little Jimmy. See how he's climbing up there." She would give a running commentary on the behavior of little Jimmy, getting the mother to identify herself with her and see the child through her eyes. Pauline Stitt is another person who is very good at this. She will say to the mother: "Look at this baby. Look at that little smile," and make what the baby is doing meaningful. In situations of this kind the worker is talking about a separate person. To her the child is a separate individual. The mother identifies herself with the worker, and at that moment there is a mother-child separation.

At the other end of the scale, you would have the kind of women who, during pregnancy, talk only about older children, obsessional, somewhat cold women, who seem distant from people generally. You want to bring these women closer to their babies. Again, you try to shorten the distance between the mother and child by means of identification. But this time you want the mother to identify herself with you as someone warm and close to the baby. You must also give the woman support so that she does not need to feel the baby is so dangerous. As a rule, the reason a woman is afraid to come close to her baby is that she sees the baby as a bundle of instincts. If you can make the mother feel safer in this situation, you will bring the two of them closer together.

So far we have been talking about mothers of infants, but the same principles apply to mothers of older children. This work must not stop with the first year. The chief emphasis, in planning future programs, should be on a continuity of service from the prenatal period on. Much of what you learn in the prenatal period is

¹¹ Wilma Lloyd: Group work with mothers in child-development center. *Mental Hygiene* 1950. 34, 620-640 (October)

useful in the postnatal period. If real continuity of service is impossible, there should at least be a close relationship between the people dealing with the mother prenatally and those dealing with her in the well-baby clinic. Too often, the people who look after the pregnant women have practically no contact with the people who work in the well-baby clinic.

As you can see, at every stage of the mother-child relationship, the mother is being stimulated by the child. This is a dynamic unfolding process, which is constantly changing. At 2 months it is different from what it will be at 7 or 8 months, and so on as the baby grows older. Different areas of the mother's emotional life are successively affected by it.

Restimulation of old problems

Special difficulties arise in connection with habit training. A woman who has herself had difficulty in regard to dirt and cleanliness, is likely to be ineffective or insecure in dealing with the child at this stage. Problems from her own childhood may be restimulated, and she may be in danger of stereotyping the baby as dirty. The hysterical woman is more likely to get into difficulty later on, at the Oedipal stage of the child.

Women come into a clinic absolutely distraught, saying, "What's the matter? The little boy holds his penis," or "The little girl sticks her fingers into her vagina." What has happened is, that the child's behavior is stimulating the woman's own feelings of guilt. Perhaps she masturbated during adolescence. Now one of the very hopeful things about working with mothers of young children is that, because of their intimate contact with these early stages of development in their children, they themselves go through a series of crises which can be used for their benefit. As was the case in pregnancy, during the child's early life old problems keep bubbling up to the surface, and the woman goes into states of unstable equilibrium. Everyone who works in well-baby clinics knows the amount of emotional upset expressed by many mothers over apparently trivial things.

These upsets are associated with the revival of old problems of the mother's now coming to the surface because of stimulation by parallel problems in the child. This may be painful to the mother, but it offers a great opportunity to the child-care worker or mother-care worker. When one is in crisis, only a little touch is needed here and there to tip the balance. A little movement in the right direction may solve not only the problem of the child but also the problem of the mother. But this is true only at a particular

moment. A little earlier or a little later, and the same amount of effort would produce very little.

In other words, the mother's problem may be handled on the crisis basis instead of through routine psychotherapy at some other time. In psychotherapy one must stimulate crises, artificially, by therapeutic techniques. This is a long and laborious process. In the case of a pregnant woman or the mother of a young child, nature provides what a psychoanalyst has to work a long time to bring about.

The mother will have a series of crises during the development of her child. These are inevitable and not necessarily bad. They can be advantageous, providing the woman has the right kind of emotional environment and is in contact with the kind of people who will help her toward a positive and healthy solution of the problem. It is possible that, as the child grows and develops, the mother too may become more mature, because with each successive problem she solves for the child, she also solves one for herself.

Pathological pressures

We have talked quite a lot about the unfortunate results that may arise from certain pathological pressures in the environment, but these pressures do not necessarily lead to poor mother-child relationships. Even a woman with a neurosis or psychosis may have a very healthy relationship with her child. That may surprise some of you; it did me when I first came across it.

I once treated a woman in Jerusalem who was quite crazy, and had been for years. She had a very bad family life. Her husband was in jail at the time. She was his sixth wife, and I do not think he had gotten rid of some of the others. In any case, he was a well known brigand. This woman brought her child of six to the clinic because she thought he was stealing. He had taken a pencil home from school and she considered this stealing.

Talking with her, we got a depressing picture. She said the child wet the bed and had encopresis; that is to say, he messed himself. And he was very aggressive. But when we examined the child, and we examined him very carefully because we couldn't believe our eyes, he appeared to be perfectly normal. He was a little aggressive and noisy, when compared with a child from Paris or London, but by the standards of his own environment, he was perfectly normal. When we asked him about wetting the bed, he explained, first, that his mother could not afford to buy blue paint to put around the door; then, that there were ghosts outside and if one did not paint around the door with blue paint the ghosts came

inside; and, finally, that in order to urinate at night he would have to go into the night where the ghosts were. It was very logical that he should wet the bed. As for his encopresis, as we talked more with the woman, we discovered that this was due to the terrible food she gave him. He had diarrhea most of the time, and the hand-me-downs he wore were very difficult to undo. By the time he could unbutton his clothes he would mess himself. Altogether, he seemed a perfectly normal little boy.

She told us that she beat him terribly, and was afraid he would get epilepsy as a result. This sounded pretty bad. I asked: "What do you beat him for? Do you beat him when he wets the bed?" She said: "No! What do you expect him to do. Everyone knows that a child wets the bed." I asked: "Do you beat him when he messes his pants?" She said: "What do you expect? He can't take his buttons off. He's got diarrhea. How would you expect him not to mess his pants. You wouldn't expect me to beat him for that." She also told me he masturbated. I asked, "Do you beat him for that?" She said, "No, that's normal. A little child plays with himself." I asked: "Do you beat him for stealing?" "Oh no," she said, "After all, that's hereditary. His father is a brigand. At the moment he's in jail. I wouldn't beat him for that. Who would beat a child just because his father was a criminal?" Finally I asked, "What do you beat him for?" And she answered: "I have a severe noise in my head, and every now and then I get very nervous because of this. The children make noise. I would hit him with my hand, but I've got rheumatism in my hand, so I hit him with a stick. Only I'm afraid if I hit him with a stick he'll get epilepsy."

When I spoke to the child, he didn't seem to mind. His mother had always beaten him. He said, "When mother gets nervous, she lets fly with a stick."

The interesting thing here is that the mother-child relationship was successful and very healthy. Whatever needs the child had the woman was fulfilling. She was very warm and protective and she braved the child guidance clinic because the child had stolen a pencil.

Here was a woman with a frank psychosis, living under terrible conditions. Yet this was a healthy mother-child relationship and it had produced a healthy boy. There was also a twin sister who seemed very normal. All of this showed us that a woman can have a gross disorder of personality and yet, if her relationship with her child does not involve that part of her personality which is disordered, you may get a child with a healthy personality.

Again, in the Family Health Clinic in Boston, we have a woman with two lovely children who were born in our clinic. This

woman suffers from very distressing psychiatric symptoms, an acute depersonalization syndrome. She feels as if she is in a trance or a dream and the whole world is unreal. This developed after the birth of her second child. But she has managed, in spite of it, to have a free and healthy relationship with both her children.

On the other hand, you find women with healthy personalities, who have good relationships with their husbands and families and friends, and with, say, 3 out of their 4 children, but, with one child they have a disturbed relationship. This can be explained by the fact that the woman has a whole range of problems, which she solves in a whole range of ways, some of them neurotic, some of them reality based; and some of her problems are being solved at the expense of this child, by using this child and it is this that is producing the disturbed relationship.

The immature mother

If the mother is immature one must help her to feel that she has a right to be a mother. Usually she is afraid to be an adult, afraid to be a mother. However, I would not be too quick to give a 14 or 15-year-old child permission to be a mother. You cannot prevent her being a mother biologically, but I would want to know something about her cultural background before I urged her to take on the full mother role. It may very well be that this is not required of her in her circumstances.

One must be careful not to work contrary to the girl's culture. One ought to know, for instance, what part her own mother is going to play. In many cases, our best approach might be to support the grandmother and do everything we can to prevent tension between the grandmother and the mother. As long as the infant has a stable mother person, it does not make too much difference whether she happens to be the biological mother, or the grandmother, or a foster mother who has no relationship biologically with the child.

The normal average mother

We have no statistics on what proportion of our women make normal, average, everyday mothers. That is an amazing thing, because of course this is an elementary question. There have been no studies either of the related question: In any population what percentage of the mothers have healthy relationships with their babies and what percentage have disturbed relationships? This might seem like an easy question, but the answer is difficult to get. It would require a complicated system of screening in order to separate the healthy relationships from the unhealthy relationships.

Some work of this kind was started a number of years ago in Israel, but we haven't any definitive results as yet. I made a screening of about 400 mothers in a well-baby clinic, which drew a pretty random selection of the surrounding population. My impression is that, using the screening device we worked out, which may or may not be a valid one, we found that about 5 percent of those mothers appeared to have disturbed relationships with their children, and that there were another 7 to 10 percent which were doubtful. I would say in that population between 5 and 10 percent of the mothers had relationships with their children which were sufficiently disturbed to be picked out by the admittedly crude screening devices which we used. However, you cannot generalize from a population on the east side of Jerusalem, which has a very peculiar set of people. The figure 5 to 10 percent seems to me to fit my clinical impressions in other circumstances, too, but it would be wrong to generalize this and say the same proportion held in San Francisco. Given a different population, a different culture, different forces at work, and you would have to make a new count.

One may wonder how the above figure fits in with the fact that 50 percent of our hospital beds are for mental patients. But the mental patients in hospitals represent an accumulation of psychosis over the years, and we are talking about the incidence of one pathogenic factor in the population, namely, mother-child relationship. Obviously, it is not the only pathogenic factor, and we are not sure in how many cases it leads to psychosis. In order to have, say, 4 per 1,000 of your population in mental hospitals, you need only a small number of people who have the kind of pathogenic factors which operate throughout their lives. How many pathogenic factors you need in order to arrive at a cohort of a certain number of psychotics at sometime during their lives is a complicated mathematical, biostatistical problem.

Disturbed father-mother relationships

Some authorities have drawn attention to an association between the relationship of the parents to one another and sleep disturbances of the child. There is undoubtedly something in this. But it must be remembered that in recent years there has been a movement away from feeding disturbances to sleeping disturbances among children. A few years ago in well-baby clinics, what mothers complained about most was feeding disturbances. Since then, as a result of the procedures and the policies of the pediatricians and nurses in the well-baby clinics, the increased freedom in the feeding situation, and the departure from the old, rigid scheduling, and so on, these feed-

ing disturbances have decreased. As these feeding disturbances decreased, however, sleeping disturbances have increased. I suppose the commonest complaint in well-baby clinics now is about a sleeping problem.

There may be some connection between these. If the mother gratifies the child in this fairly free way in regard to feeding, the child may not want to leave her at night. It may not want to go to bed because this means leaving the gratifying situation. Be that as it may, we cannot say that all sleeping disturbances should be regarded as signs of marital disharmony.

But sometimes marital disharmony is an important factor. Sometimes where the child cries persistently at night the woman tells you: "Well, he cries very hard, so I have to keep him with me in my bed. My husband, of course, works hard all day, so he has to sleep in the other room in order to get a bit of sleep, poor fellow." She will tell you the baby cries every hour on the hour, and say: "I have to keep waking up every hour to look at the baby." And you find out that she does indeed wake up every hour. She goes to the baby. Sometimes he is not crying, but she finds him twisted around and puts him straight, and with that he starts crying.

This kind of behavior may sound funny, but it is quite common. You naturally ask yourself, "Why is this woman keeping the baby awake at night and all that kind of thing?" If it all started 1 or 2 months after the baby was born, you suspect the woman may be using the baby as a contraceptual device. As long as the baby is awake and she is tired, she cannot have intercourse. If she has no other form of contraception and no other way of avoiding coitus, and coitus is distasteful to her, you can suspect this explanation of the baby's sleeplessness. It is surprising how often you find just this situation.

Infertility

Several studies have been made of the emotional aspects of women who suffered from infertility and afterward become pregnant. I myself wrote up one case in a paper called, "The Mental Hygiene Role of the Nurse in Maternal and Child Care."¹² It was the case of a school teacher who wanted very much to have a baby. For years she went the rounds of the fertility clinics, and eventually they said to her: "We're very sorry. You'd better give up. We've done everything we can. It's too bad." So she gave up and made plans to go on a trip around the world with her husband. And just then she became pregnant.

¹²See appendix, p. 257.

She came to us at the clinic roaring mad. I think she is the only woman I have known who rejected the pregnancy until the moment of birth. She used to come in and gripe about the situation. But she was worried, too. She kept saying: "What kind of mother am I going to be if this is the way I'm behaving in pregnancy? And how strange, because I wanted a baby so much." I said, "I don't think what you're saying about your pregnancy has anything to do with the kind of mother you're going to be. I think you'll be a perfectly adequate mother." She hated her pregnancy until the moment of delivery. But the next day she was pleased as Punch with her baby, and was breast feeding very happily within 3 or 4 days. She turned out to have an excellent relationship with her child.

It is not uncommon that women who have been told that they cannot have children have adopted a child and then become pregnant. This suggests that there are psychogenic factors in the sterility. It happens far too often to be a coincidence. Flanders Dunbar¹³ has written at least one paper on this subject.

If there are psychogenic factors producing sterility, and the woman becomes pregnant for one reason or another, the question must be asked: Have those earlier conflicts been worked through satisfactorily? If they have not, you are faced with a woman with deep-seated feeling against having a child, who is nevertheless going to have child. In such a situation there is always the possibility of a fundamental disorder in the mother-child relationship. Very often a woman of this kind needs specialized help and not the kind of superficial help that can be given by a nurse or a pediatrician.

Head banging

Whether there is a common factor in mother-child relationships of infants who do a lot of head banging and rocking has not yet been ascertained. You will find in old psychiatric books that head banging, or crib rocking is a very serious symptom. The reason for this is that psychiatrists who examined children suffering from childhood psychoses discovered that a lot of these banged their heads. But they had not examined the healthy children who were also busy banging their heads.

Head banging of some sort is very common among children. All we can say is that primitive movement is rhythmical and a type of comfort device. You will find this among babies. You will find

¹³ R. Squier and F. Dunbar: Emotional factors in course of pregnancy. *Psychosomatic Medicine*, 1946. 8, 161-175 (May-June)

it among adults in certain cultures. In certain religions shaking is part of the religious ritual. In Indian cultures and Jewish culture, people shake themselves back and forth when they pray. This apparently gives them some deep feeling of comfort. When they want to get close to their Maker they shake themselves. The same is true of the Shakers in this country.

Rooming in

"Rooming in" or the practice of keeping mother and child together in a hospital, is a recent fad often associated with natural childbirth. Certainly the time lag in the development of maternal feeling is going to be shortened if you have the mother in close contact with the child from birth. For many mothers this will be a good thing.

But if you apply this principle generally, you will place a considerable burden upon the development of the mother-child relationship for many other mothers. The woman who is afraid of the baby because she sees it as a little bundle of instincts is going to have her fears very much increased if she is not able to escape from the baby immediately after birth. There's a significant proportion of mothers to whom rooming in is traumatic.

I have been asked whether babies born at home lose some of the benefits of babies born in the hospital. It would seem more natural to ask the question the other way around. The American attitude that labor and delivery is a surgical procedure is peculiar. This is one of the few countries where such a tradition exists and where, therefore, people feel that if a baby is born at home it is missing out on something. In many western countries and certainly in most eastern countries, birth at home is regarded as the normal thing, the type of birth you want for your child. Only the abnormal cases go to the hospital.

There is a beautiful film produced in Georgia called, "All My Babies,"¹⁴ which shows a Negro midwife going her rounds and delivering a baby in a poor home with the family all around. They had natural childbirth there, without anesthetic, and they had rooming in. Professional natural childbirth seems a little forced in comparison.

The woman's choice for or against rooming in is likely to depend upon the local hospital tradition. A woman may feel re-

¹⁴ "All My Babies." Produced by George Stoney for Medical Audio-Visual Institute of Association of American Medical Colleges under the auspices of Georgia Department of Public Health. 1953. Distributed by Center for Mass Communication, Columbia University Press, New York. 55 minutes, black and white with sound.

luctant to single herself out. On the other hand, if a hospital offers an opportunity for rooming in I would consider that a good thing. But I object to rooming in when it becomes a fad, a sort of moving-belt factory operation, which it very easily can. It can because obstetric hospitals are usually run on the moving-belt principle. They are very effective when run that way. The spectacular reduction in maternal and infant mortality, which has followed the advances in modern obstetrics, has come about as a result of carefully worked out fine details of techniques and their application on a large scale. From the physical point of view this is excellent and important; a good obstetric hospital runs like a machine. The difficulty is that this leaves out of account the human elements. It is very hard not to leave them out. I am afraid that if you start bringing in the individual human elements, you are going to upset the machine.

There is no doubt that to be close to their babies immediately after birth is a decided advantage for many women. But I do not think that anything very terrible happens if there is some time lag in the development of maternal feeling, as long as the woman knows about it and is expecting it.

Geographic Separation of Mother and Child

We have talked about the necessity for psychological separation of mother and child. Bowlby¹⁵ of London, Spitz¹⁶ of New York, Roudinesco¹⁷ of Paris, and others have studied the effect of too much separation of mother and child. They have been concerned in particular with geographic separation.

Naturally, you can have psychological separation without geographic separation. A mother's relationship with her child may be a very distant one, even though the two are living in the same room. But when you have geographic separation, there is no opportunity for the kind of communication we have talked about to take place. You must then ask what substitute mothering care is available for the child.

During the first 4 or 6 months, that is to say, before the development of the whole-object relationship, geographic separation with good substitute mothering care does not seem to have any marked ill effects. If, on the other hand, you get separation at this period

¹⁵ John Bowlby: *Maternal Care and Mental Health*: A report prepared in behalf of the World Health Organization. New York: Columbia University Press, 1951, 179 pp.

¹⁶ Rene A. Spitz: *Hospitalism, Psychoanalytic Study of the Child*. New York: International University Press, 1945. (p. 53)

¹⁷ Roudinesco and G. Appell: *Les repercussions de la stabulation hospitaliere sur le developpement psych-moteur des jeunes enfants*. *Semaine hop.* Paris, 1950, 26, 2277-2273 (June 26).

without adequate mothering you get a gross disorder of ego development. The child grows up to look like a mental defective.

Later, after the child is able to recognize a whole object, that is, a whole person, separation of mother and child produces bad reactions even with the best substitute mothering. When the child has built up a relationship with a mother or a mother person there is a bond between them. If that bond is interrupted, it hurts. This is a traumatic event with measurably bad effects. If in addition no substitute mothering is provided you get other bad effects. The child then has the bad effect of having lost its loved one and the bad effect of not having its needs satisfied.

The question is, when there has to be separation of mother and child, how much separation must occur before ill effects are produced? In other words, is it sufficient at 4 or 5 months, if the mother has the baby at night? No one can say, at present. More research is needed on this point. But so far as we can tell, if the mother has the baby for a period every day, that bond continues and the child does not suffer greatly.

If, in the second half of the first year, you get a prolonged separation of more than a few days, the baby becomes depressed and mourns the relationship that it is missing. Spitz calls this the anaclitic depression, meaning the depression produced when "leaning together" is interrupted.

Spitz has described what he calls "hospitalism" in babies in the second half of the first year. This is a mixed picture, a combination of the anaclitic depression and the lack of mothering, which takes place in many institutions where the child's needs are not perceived. In such institutions the child is simply stuck somewhere and expected to stay there. This hospitalism leads to a profound depression of all the developing facets of the personality, and to profound physical depression. Many children die of this.

These children, if you look at them, present a very sorry picture. They are cut off. They retire from the outside world completely. They are not capable of being stimulated by the outside. They just stop developing. In the less severe cases, the child is merely stunted. He is backward in speech development and backward in motor development. He is retarded in all ways. Of course the intellectual development is stunted, since intellectual functions go hand in hand with the emotional stimulation of relationships with other people. These children, who have been separated from their mothers at birth or soon after, at about 2 or 3 years of age look like mental defectives.

What happens with slightly older children? If you separate the mother and the child, after a relationship has been established

between them, the reactions you get will depend upon the character of the previous mother-child relationship. The reaction will depend upon whether the mother-child relationship was healthy or ambivalent, on the length of the separation, and on the age of the child. The younger the child, the shorter the separation needed to produce bad results. The more unstable the previous relationship, the shorter the separation needed. That is, if you have a stable, healthy, mother-child relationship, the child can stand a great deal more separation, or stand the same amount better.

Stages of reaction of child

When a child of about 3 years of age goes into a hospital, or is otherwise separated from his mother, he goes through several stages of adjustment. These are beautifully illustrated in a film produced by Bowlby and his group of workers, called "A Two Year Old Goes to Hospital."¹⁸ The film was actually produced by James Robertson, a psychiatric social worker in the Bowlby team. It describes the day-to-day emotional manifestations of a lovely little 2½-year-old child who was in a hospital for 7 days for some minor operation.

The first stage which we see is one of protest. The child weeps and cries and shouts, "I want my mommy. I want my mommy. Where's my mommy?" and presents a very sorry picture. The second stage is one of despair. You can see the child getting depressed. She now believes her mother has left her, and no amount of verbal explanation is going to seep in. The child begins to believe her mother has thrown her out and works out some fantasies as to why that is. She must have been naughty. She begins to feel very angry at her mother and then becomes angry at herself for having been so naughty. The first stage may last 3 or 4 days, or even a week or two. The second stage of despair which follows may also last a few days to a few weeks.

Then you get the third stage, which is a stage of adjustment. The child adjusts to the situation. Children are pretty adaptable; they will usually adjust. But the adjustment may be an unfortunate one. In the film I am describing, toward the end of the week the child adjusts by denying her own unhappiness. She puts on a smiling face. She begins jumping up and down and clapping her hands. She is trying to persuade herself: "I'm doing now the things I used to do when I used to be happy," but it does not quite

¹⁸ "A Two Year Old Goes to Hospital." Produced by James Robertson, Tavistock Clinic, London, England, 1952. Distributed by New York University Film Library. 50 min. black and white with sound.

work. After making the movements, you see the child's face becoming depressed and miserable. This child has a very expressive face and you can see the emotions playing back and forth as she fights against her despair and pretends she is happy. She then goes a stage further and denies the need for a mother. This works. She says to herself, "I'm not unhappy any more because I don't need my mommy. I don't need my mother."

A little later, the child forgets her mother and we have a characteristic picture of the child in a hospital. When the mother came to visit, the child did not recognize her. The mother came and the child turned her head away. The mother had to talk to the child for about 10 minutes before the child recognized her.

In the case we are describing, after this period of hospitalization the mother went off to have a baby and the child was placed with her grandmother for 2 weeks. All the time she was there she kept shouting, "I want my mommy. I want my mommy." But when her mother came home from the hospital, the child looked at her and kept on saying: "I want my mommy. I want my mommy." It took about 3 days before she could believe that this was her mother. As you can imagine, this was a very harrowing situation for everyone.

These stages vary in their duration. You sometimes get the whole process taking place within a few weeks. If the stage of denial of unhappiness lasts for very long, and there is no substitute mothering, you may get a gross damage to the ego structure. It was cases of this kind that first attracted Bowlby's attention. He was investigating the personalities of young thieves or young criminals, and discovered that in most cases those with psychopathic personalities had had a prolonged separation from the mother below the age of five. It seems that if you want to manufacture psychopathic personalities, criminals and prostitutes, the way to do it would be to take children below the age of five away from their parents and place them in institutions and leave them there for 5 or 6 months. Not all the children treated in this way would turn out criminals. There are other factors operating, too, although we are not sure yet what they are. But only a certain portion of the children who suffer these deprivations have these results.

Older children go through the same stages to some extent. In fact, all of us go through them to some extent if we are facing something very unpleasant, such as separation from our wives or husbands or children. But the experience does not have the same damaging effect, apparently, when one is above the age of 6 or 7. The damage occurs only when the child is in a vulnerable stage of personality development. It is like the case of a young shoot—by

bending it slightly you can distort the whole development of the tree. Wherever possible hospitalizations of children should be delayed until the child has reached the age of 4, 5 or 6 years. With male children, one should also try to avoid operations during the 4- to 6-year period.

Hospitalization of a child

It is good for the hospitalized child to have visits from his mother, but hard on the hospital routine. The children cry, especially when the mothers go away, and nurses say: "This is a nuisance." It certainly is a nuisance. And they point with pride to some children who are not visited and who, when their mothers come after 2 or 3 weeks, do not cry. The nurses say, "These children are good children." But actually these children have reached the stage where they are likely to be damaged. The nurses may be pleased, but the psychiatrists are displeased when they see this.

After children have been institutionalized for some time, you get a peculiar dulling of their interpersonal relationships. They seem too happy. When you come into a ward of institutionalized children, if you just stand in the door and click your fingers or dance up and down or pat your hands, the children all laugh. You think you are a marvelous comedian. Pediatricians and others who visit children in wards have discovered this, and many pediatricians fancy themselves very great comedians. Each has his own little clicking sound which he makes, and the children are delighted. This delight is not a manifestation of cheerfulness on the children's part. It is a manifestation of stimulus hunger. They are anxious for any kind of social stimulation; they are so hungry they swallow down anything you give them.

But if you walk into that ward after you have stood in the doorway and made the clicking sound with the children clapping and applauding you, and move toward one of the cots where a 3-year-old is standing, he flings himself away from you, and if you lift him up he turns his face away. He can only be happy at a distance. As you get closer to him, he is forced into an interpersonal relationship and turns away.

As the children grow older, they adjust even further and stop turning away. In those who have been institutionalized a long time you get a sad picture of promiscuity. They are friends with everyone. They are like little prostitutes, and many of them actually become prostitutes. They can share their relationships because these do not mean anything.

What of the child who expresses his feeling about separation overtly, the child who is put in a hospital, and after a few weeks begins pulling his hair? This is partly an individual personality pattern. Most of us believe that people who express their feelings are better off than people who do not express their feelings. But a child tearing his hair is not just an expression of feelings; it is a symptom of something more. A better expression of feeling would be for the child to play out or verbalize some of the fantasies engendered by his experience. Children have very terrifying fantasies about a situation like this.

I read recently a beautiful account of the reaction of children to a tornado. A tornado had struck the town. A number of children had been killed and others were involved in one way or another. Some investigators undertook to find out how the children had reacted to all this. What they were especially interested in was, how did the adults help the children deal with the trauma of this disaster? They found more or less what they had expected. Parents who had previously had a healthy relationship with their children were able to help them in this particular situation. But some of the recommendations made as a result of this study are of interest to us.

It was suggested that, whenever able-bodied persons are called upon to help in the general reclamation work following a disaster, it be laid down specifically that mothers of young children have a primary duty to stay at home with their children. That is, their first duty to the community is to stay with their children. The mothers are needed at home to deal with the immediate emotional upset of the children and to give them support. It was also suggested that school be resumed fairly quickly so that the children could come together and get some feeling of group solidarity from each other. The lessons for the next week should be expressive rather than learning lessons. The children should not be studying arithmetic but should be busy painting or drawing or talking. This will give them a chance, if they need it, to express their feelings and have these supported by the teacher and the other children. It was pointed out that teachers might feel they should get the children to work and make them forget what had happened, but that this would impose an extra strain upon the children by denying them an opportunity to work through their problems.

I regard this document and the recommendations based on it as a fine example of the elaboration of a public health mental health policy. Here people first studied what occurred during a crisis and then made suggestions for the community, which would have the effect of preventing future unfortunate results.

Hospitalization of a mother

What can we do when a mother has to be hospitalized and so leave her children? I think the important thing is to keep the children in the home and in contact with their other relatives, if at all possible. The worst thing is to split the family and put the children into institutions. But this is sometimes necessary, and what then?

The problem is well illustrated by a Negro family we have been studying in Boston. The family consists of a mother and father and seven children. The three older children are boys. Then come four girls. The father works 76 hours a week and earns \$47. He is not very bright, and is, generally, a rather passive individual.

The family came to our attention because the second from the youngest girl, aged 4, was thought to have tuberculosis. And it turned out, either she did not have it or if she did it had cleared up. But we maintained contact with the family because we suspected that someone else in the family might be tubercular. We maintained contact, and built up a relationship with them.

It is not easy for white investigators to build up a relationship with lower-class, colored people, but we succeeded fairly well. Then, as we suspected, the mother was found to be suffering from tuberculosis and had to go into a sanitarium. Because of certain peculiarities of the settlement situation she was sent to a sanitarium 50 miles away.

We have learned a great deal from this family. At least, we have learned from them one of the ways in which a family may successfully adapt to a situation of this kind.

I suppose if this fellow had been brighter, or if we had wanted to take a service role in the situation, we might have suggested that he go on A. D. C. But we did not do this, because we did not want to interfere. If he had done this, he would certainly have had more money without working, since he had seven children, than he could earn for his 76 hours a week. But that would have been a severe blow to his self-respect. As it was, he was earning the family's keep. As it was, he decided to keep the three oldest, the boys, with him and put the girls in an institution. However, the youngest girl was too young for an institution so she was sent to a foster home.

When people are under stress, you get a certain succession of events as the stress increases. First you are likely to have a depressive effect. But as the stress reaches a certain intensity you get, in many cases, a sudden mobilization of the strength of the individuals and the group. This is what happened in the case I am describing.

Under the impact of the initial doubt about the diagnosis this man was depressed and less effective than usual. Then, as it became clear that his whole family was in danger of breaking up, he suddenly changed his way of acting altogether. He became quite active and went around to see the social workers at the various child welfare agencies. He and his wife went and inspected the Preventorium, the institution where the girls were to be placed, to see if it was suitable for their children. And he agreed to pay \$5 a week. It was something new to the people there for a man in his position to be willing to pay. He also inspected the foster home where the youngest girl was to stay. In each case he took his wife with him, so she could see where her children were going to be while she was away.

He did one other thing which was quite dramatic. In a sense, it was also quite pathetic. He gathered his children together in two groups, the boys and the girls, and appointed a captain for each group, the oldest boy and the oldest girl. He told the boy: "You're going to be with me, but I'll be at work, so you're in charge of your brothers when you're separated from me." And he told his 8-year-old daughter: "You take care of the girls. You know mommy's going away, and you must take care of them. If you want me when I'm at work, I'm on the phone." Then he sent one of the children out to buy a little notebook. He tore out pages and wrote his telephone number on them and gave one to each child.

The children went off holding their father's telephone number. When the three got to the Preventorium, one of them left the paper in her coat. But she ran back and got it and kept it with her all the time. It was a link with her father.

He said to us: "You know, the family comes first. Even though I have to lose some time from work and the boss may kick me out, I must go around and visit these children." So he went around. He went to the Preventorium and to the foster home and kept in touch with all the children.

One day he approached us and asked: "Would you give me a lift out to the sanitarium?" We were very pleased to do this. And we were also pleased that he had taken the initiative to ask for it. His children have been separated. He cannot prevent that, but he does his best to keep them together and maintain channels of communication.

This man worked 76 hours a week for \$47, and the first 6 months we knew him we hardly got a word out of him. I do not think this was because of his lower economic status. We felt that it was due, at least in part, to communication difficulties between Negroes and whites. During this period, he got used to talking with white

people, and professional people. He then gives us a blueprint of one way of dealing adequately with a situation of this kind.

There was one other interesting point. This man had a brother, but he refused to ask help from him because, as he said, "My brother also has difficulties." He had practically no contact with his brother. But he overcame this to the extent of asking his brother to give him and the boys a lift out to the sanitarium. The children were not allowed in, but he was able to show the boys the place where their mother was. They travelled 50 miles, there and back, just to see the building, but it meant a great deal to them. They were all very miserable, of course, but they were coping with the situation. There are always things one can do. We are learning from this family what some of these are.

What happens if you have to take a child away from its parents for any prolonged length of time? I think the principles just illustrated hold. First, you should do your best to maintain the channel of communication with the parent figure. And you should do what you can to avoid the impersonality of institutional care.

Large institutions cannot be run in a personal way. Therefore, one should think as much as possible in terms of small institutions, or of small units in large institutions, where some consistent relationships can be built up between the children and other individuals. The three shift system, which is so common in institutions, is bad from this point of view. But from the point of view of institution administration it is most effective. This is just one illustration of the fact that the way in which we run an institution may be inimical to the mental health of the inmates. I would say that the best means for producing prostitutes and criminals, people who will have to be cared for at public expense for the rest of their lives, are the large orphanages and children's institutions, which are, even today, fairly common. In England they have recognized this, and the policy today is to tear down such institutions and replace them either by small cottage-type institutions or by foster homes.

Adoption

The question of adoptive procedures is a complicated one. I do not think we have worked out anything which is really effective in this area. Bowlby gives a great deal of attention to the problems of unwed motherhood, since this is the source of a significant proportion of the separated children that we find in institutions.

I think the fundamentals we have been talking about allow us to set up a few general principles. If you have an unwed mother,

you should do what you can during her pregnancy to help her to plan for the baby. If her circumstances are such that she can keep the baby and there seems to be some stability in her setup, there is no reason why she should not keep it. But, in our present social system, the odds are that the girl will end fairly quickly by placing the baby somewhere. You then get the development of the mother-child relationship which has to be broken.

If you have decided on adoption the question is, when should the baby be removed from his mother? Here, again, we can base our answer upon what we have already discussed. We have to think, not only of the child, but of the mother. If the girl does not see her baby at all, will that be harmful to her in certain aspects of her own development?

By and large, a woman will not develop much of a mother-child relationship, or much maternal feeling, unless she actually perceives the child. So, if a girl has decided to give up her baby, the best thing would be for her not to see it at all. In this case she does not develop a mother-child relationship. But she has forsaken her baby. And it is probably more difficult to work this through when she has not seen it than when she has.

I suppose, other things being equal, if a baby could be adopted immediately after birth, that would be best from the point of view of the child's personality development. But there are other issues involved. Adoptive parents usually demand more safeguards than would be possible with a baby of their own. They usually require a period of supervision of the baby in order to see if it is "normal."

Then there may be legal problems. I would say that if the laws of your particular area forbid adoption before a certain age, you should at least arrange to have the baby fostered with a stable mother figure for whatever period the law requires before the baby can be adopted. In that case you will have to deal with the trauma of the breakup of that relationship. But this is better than having the child in an institution where there is no possibility of building up any kind of relationship with a key figure. You have to choose between all sorts of alternatives, none of which are perfect.

Gross congenital deformity of the child

There is a terrible thing that happens in many obstetric hospitals. When a girl gives birth to a baby, with a gross congenital deformity, which is expected to die, it is the custom to protect the girl and not let her see the baby. This produces a very difficult problem. The girl cannot work through her grief at the loss of her baby because she has not seen the baby. The obstetricians say that

seeing the baby would upset her. It would. But she will be much more upset by fantasies of the horrible monster to which she gave birth. However horrible the baby may look, the fantasy of what it might look like is worse.

Earlier, I mentioned a girl who lost her baby because of congenital anomalies. This was a sad experience. The chief of the obstetrics department where she was, ordered the nurse to remove the baby to another ward and not to let the mother see it. She was boiling with rage. Then her own obstetrician braved the ire of his chief and took the patient down to the other floor where the baby was, went into the nursery with her, and got the baby and handed it to her to hold. This upset her very much. But afterwards in analysis, she said to me: "Now I'm so grateful to that man for letting me do that. At least now I know what my baby looked like, and although it's painful I feel I had a relationship with that child. To everyone else she was just a deformed baby, but this was my baby, my little girl. She died, and I keep remembering over and over again how she looked when I held her in my arms."

This woman managed to adapt herself to the situation within about 5 weeks after the birth of the baby. She told me, "I've never in all my life been as sad as during this period; I've never suffered as I've suffered during this period." But she is now pregnant again. She certainly has a scar, but she has been able to weather the storm. And that is partly due to this obstetrician who dealt with the situation in a good mental health way.

Every case has to be decided on its merits in terms of what you know about the particular woman and in terms of the degree of deformity of the baby. This is the only reasonable way to proceed. But if you make a rule that mothers should never see babies like these because it would upset them, I say it is the doctors and the nurses you are afraid of upsetting.

Death of parent

There is some question about what should be done when a child loses a parent in death. Should the child be quickly removed from the home so he will not be associated with the funeral and so on? Should he not see the dead parent in the coffin? What effect does such a sight have on a child?

This is a matter where culture plays an important part. I am probably a little under the influence of Evelyn Waugh's horrible book *The Loved One*, and of other descriptions of how the dead are painted up and people go and look at them and have a fine time.

But things like this are culturally determined and have to be accepted, to some extent.

I would say, however, that we should be wary of projecting adults' ideas of death into the minds of children. I was very much impressed one day when I was riding with my sister and her two children, one of them 3 years old, and the other 5. We passed a beautiful cemetery, and my brother-in-law said, "My father is buried there." The children picked this up and began asking questions about death, how people die, how grandfather died, and so on. The mother answered these questions in a matter-of-fact tone. She told them that grandfather got very old and he died. The children's attitudes toward death were quite different from the attitudes of the grownups. They were not upset by the idea that grandfather was buried in that ground over there. They did not have the fantasies that the rest of us do when we think of actually being in the ground, and so on.

I do not think it is anywhere near as traumatic to children to have contact with death as adults imagine it to be. But if you start bending over backwards and inventing fairy tales, you may stimulate fantasies in children which can be very harmful.

Reunion

I think you can handle any situation if you realize the problems involved. Take, for example, the mother who has been hospitalized for tuberculosis and whose child has been cared for by someone else during its first 6 or 7 months. It will certainly be traumatic for the 6-month-old baby to move from what it regards as its mother to some strange woman. A period of adaptation will be necessary. It will be painful for the child and painful for the mother. It will also be painful for the foster mother. But it can be done. It is amazing what emotional burdens people can adapt to.

But there are healthy ways of adapting and unhealthy ways. One can think of many unhealthy ways of dealing with such a situation. This is where the care-taking agent is very important. If, for instance, the woman comes home thinking: "I haven't had the baby for 6 months, but it's my baby and should immediately recognize me as its mother. I should have maternal feeling," there will be difficulties. But if someone has worked with the mother for a while and has said: "After all, you haven't seen the baby until now. It wasn't the woman's fault that she had to act as the mother. She didn't want to steal your baby from you. It wasn't the baby's fault either. The baby feels that woman is his mother. You mustn't expect him to recognize you as his mother, even though you

really are." That may take a few months, then the woman may be able to move in a healthy direction. She will have been guided and supported. It will be a difficult emotional problem, but it can be met.

In doing this, one must take into account the woman's fantasies during these 6 months. One must work with her. One must realize that for that woman a period of emotional work is involved, just like the period of emotional work involved in a bereavement situation. Any transition of this type involves a period of 4 to 8 weeks, during which one must reorient one's life and bring reality up against one's internal fantasies, which usually have not been based upon reality.

The father

If the father has cared for the child at home, the woman is likely to be jealous of her husband because he has had the care of the baby during this period. This will affect her relationship with him. But again these are problems which can be worked through. They do not inevitably lead to difficulty. It is a stress situation, and people working with the father should realize the kinds of problems he is facing and support him in trying to work out effective solutions. They should realize that this is going to be upsetting for him. But it need not lead to bad results merely because it is upsetting.

The Care-taking Agent and Adaptation to Stress

It would be very valuable for those of us working in this field if we could describe the range of ways in which people adapt to stress. We are working on this in Boston now. We are taking fairly common stress situations and seeing how people actually handle them.

There are many ways of dealing with stress, some of them healthy and adaptive, and some of them maladaptive. It is the responsibility of care-taking agents to know enough about these things to be able to edge people in the healthy direction of the range. People are much stronger in dealing with difficulty than we usually give them credit for, and a good deal of the care-taking agent's work should be in removing blocks and obstacles which prevent the individuals from finding the right path, rather than in directing them which path to take.

If we knew enough about ranges of reactions and adaptations, we might be able to do a bit of directing, but at the moment we are

terribly ignorant in this area. We do not know the range of healthy adaptations to even the simplest situation. Perhaps our researches will some day enable us to draw the spectrum of reactions in many kinds of situations and possibly uncover some common elements in them, so that we can do more than just support the individual and hope that he will find the right avenue. If we learn enough, we may be able to suggest that people take a particular avenue, or point out other possibilities, and so avoid a situation where the individual has to find out these things for himself.

However, my bet is that one would never really be able to direct a person as to which possibilities he should take, because there are so many kinds of personality and cultural combinations to deal with. I think ultimately one would have to leave the decision to the person himself, but one might be able to smooth the path for him if one knew enough about how other people have handled the same situation.

Recall for a moment my case story about the Negro whose wife had tuberculosis. This experience gives us a certain amount of knowledge about how people may behave. If we had 10 or 15 variations on this theme, we would feel much more comfortable dealing with a similar situation in the future. We could say: "Now, look here, we know someone who did this, and someone who did that, and the other. These are the successful ways different people have discovered from which you may be able to choose."

This may seem more like education than casework, but I am not sure but what in a crisis situation our help is not best laid on by using procedures which resemble educational techniques more than psychotherapeutic or casework ones. One has to work quickly in these circumstances. As long as the individual is given the possibility of choice so that ultimately the choice is his, I see nothing wrong with saying: "This and this and this are the promising possibilities."

Remember the case of the girl with the deformed baby. I think that to take her down and let her hold the baby was the correct thing to do. When she talked to me about it afterward she was in analysis and I could not give her advice. But had it been a psychotherapeutic situation, when she said to me: "Look here, it is hurting very bad to think about this. Perhaps I'd better try to forget all about it," I could have said to her: "You can, if you want, forget about it, but that will not solve your problem. It hurts to think about your baby, but I can tell you that in 4 or 5 weeks you'll work this thing through. So go ahead and think about it and cry. It does no harm to cry. Crying is a very natural form of relief. It's a very natural reaction. Go ahead and cry." This is certainly giving advice

and you may say that it is infringing upon her individuality. But there are certain situations where advice, given in the right way, does no harm and may do quite a lot of good. In fact, long before we professionals came on the scene people were giving advice, all down through the centuries.

This may sound very abstract but it has tremendous practical importance. If we set ourselves the goal of removing suffering from the world, or removing stress from the world, we set ourselves an impossible goal. There will always be stress. There will always be problems. People will always suffer. Our goal should be to help people deal with these problems in as effective a way as possible. We are never going to remove all the problems.

For instance, suppose you deal with the problem of infant mortality in India and succeed in preventing the death of Indian children. You must then face the problem of overpopulation and contraceptive practices. Then you will have a eugenic problem of the first magnitude; namely, who are the people to stop having children? Are they going to be the better group or the worse group? We can hazard a prediction about this and are probably headed for trouble.

So, when you start trying to avoid the commoner biosocial problems of birth and death and old age, and these basic problems of separation or role transition, you have an impossible task. Does this mean that we cannot do anything? Should one say it is hopeless anyway, this is fate, there has got to be suffering in the world, there has got to be disease in the world, we just have to accept it and adjust to it?

No, I do not think so. I think that, given a problem and the realization that there is going to be suffering in connection with this problem, there are nevertheless better and worse ways of dealing with it. One manifestation of the mentally healthy person is that he has effective ways of problem solving. This means that he perceives reality undistorted by his fantasies. He is also able to mobilize his own resources to their maximum. He uses his intelligence and his energy in dealing with his problems, and so is able to attack them and reach some sort of reality solution.

In regard to any one of these particular problems we can set ourselves the goal of helping people find the most effective way of dealing with it. That will not remove emotional upset. In bereavement, for instance, it may be necessary to be emotionally upset. If you are not, you may not do the grief work effectively. But this type of emotional upset is not the same thing as a psychological disorder. It is a concomitant of the adjustive process. The emotional

upset of the pregnant woman, or of the mother going through a crisis with her child is not to be regarded as a pathological condition. It is not an illness. These things are sparks from the fire of life. They are emotional epiphenomena of the adjustment process. An adjustment process of any kind sets off some of these emotional sparks. Any problem you set yourself involves some emotional reorientation, and this is always somewhat uncomfortable.

CHAPTER VII

The Family Health Clinic

By request Dr. Caplan and Elizabeth Rice¹⁹ discussed the Family Health Clinic conducted by the Harvard University School of Public Health.

The Professional Team

Dr. Caplan

We have a team of 2 obstetricians, a pediatrician, a public health nurse (there is a link with the visiting nurse who makes home visits during pregnancy and afterwards), a nutritionist, and 2 social workers. In addition, I act as mental health consultant.

Dr. Kirkwood, who is head of the clinic now, has his obstetric practice limited to this clinic because he has recently become Commissioner of Public Health of Massachusetts. There is another obstetrician who is his assistant, who is also a resident in the hospital and sees the patients during pregnancy. He conducts, or is at least present at, the delivery, which is a good thing. Until he became a resident, our obstetrician saw the patients only in the prenatal period. When they came into the hospital some other obstetrician on the staff conducted the delivery.

Selection of Patients

The public health nurse attends the ordinary out-patient clinic at the Boston Lying In Hospital. The nurses there pass on to her the case records of all patients who are normal, that is, all patients who haven't heart disease or obesity, who have not had to attend special clinics, and so on. She interviews each of these normal patients. She explains our clinic to them. These are women who live in the locality and expect to be there for several years. The supervision of the family is carried on by the same team, at the Children's Medical Center. In other words, we follow the families

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from pregnancy on, and if there are future children we follow them. The Family Health Clinic does not take unmarried mothers.

The nurse describes the clinic to the women, and 2 out of 3 of them say they would like to attend our clinic rather than the general out-patient clinic. Elizabeth Rice has made a study of the third who did not accept. I do not know what the results have been.

Miss Rice

I think the reason the patient did not accept goes back primarily to not understanding the clinic. The interview with the nurse came at the end of a busy clinic period, when the mother had already seen the obstetrician and the regular nurse and was a little confused. When something else was presented to the mothers at that time they did not really get a clear idea of what the Family Health Clinic was. We felt that the study showed poor timing in the presentation of the opportunity.

Role of the Social Worker

Dr. Caplan

The first thing the social worker does is to work with the team. She covers a good deal of the preventive mental health work.

The psychiatrist acts mainly as special consultant to the social worker, who does the line job in preventive mental health. It is her role to have good relationships with the other members of the team and to understand their professional viewpoints, especially to understand why certain professions think or act in ways which do not seem the most appropriate ones to people interested in mental health. This takes time. It takes time for everyone to get to know everyone else. I do not mean just to know them personally; I mean to know them from a professional point of view.

It is also her job to see every pregnant woman and her husband, and, if necessary and appropriate, the mother of the woman or the father or the mother-in-law, or father-in-law. She must establish contact with the family and get to know something about the social and cultural background of the woman during pregnancy, and something about any intrapregnancy crises that may have taken place. Traumatic events during pregnancy are of tremendous importance to the mother-child relationship, more so than those taking place at other times. When a woman has a problem during pregnancy, whether this is social or economic, the husband's illness, or a death, there is a temptation for the mother to solve the problem through the child, that is, to prepare for a vicarious solution of the problem. For instance, if a woman's father dies, it is harder for

her to grieve during pregnancy than at any other time because, from a certain point of view, her ego is weaker then and she is more turned in on herself. She is not turned to the outside and for that reason is not as effective in dealing with the outside world. She may be less able to deal with the crises of everyday life at this period than at other times. If she is not able to grieve adequately during pregnancy, she may be tempted to work out whatever guilt feeling she may have in regard to her father's death by saying: "If I had not been pregnant, I would have helped him. It's a pity I was pregnant. I might have saved his life. I might have nursed him." You know the story. This leads her to feel that the baby is responsible. This is fantastic, but it is out of such fantasies that the disorders of mother-child relationships emerge.

The woman may develop ambivalent relationships with the baby. She may want to put the baby in the place of her father. She may transfer the relationship she had with the father to the baby. And any kind of transference of this type would disturb her relationships with the child.

If her relationship with the baby is colored by her relationship with her father who died, it is going to be a disturbed or distorted relationship. So it is the job of the social worker to maintain contact with the mothers during this period, and particularly to take an interest in the here-and-now problems of their lives. Many of our young mothers, young pregnant women who have just set up a home, are beset by the ordinary, common, garden-variety problems of budgeting, inability to work, and so on. There is a good deal of actual help which a social worker can give during pregnancy, and this help has a double function. It makes the woman more comfortable during pregnancy and increases the probability that she will get off on the right foot when the baby comes.

The social worker also pays special attention to the family relationships. She is the one on the team who specializes in giving the anticipatory guidance I have talked about. This may be specifically for the husband. If there are other children in the family she pays special attention to what happens to them during pregnancy, helping the mother to prepare them for the coming child, helping her in an anticipatory way to deal with the future problems of sibling rivalry.

Another of her important functions is to feed information into the general team conference. This is a big team. It coordinates its activities through a conference, at which every patient is discussed sometimes for 30 or 40 seconds, sometimes for 20 minutes. You may think that even 20 minutes is a very short time for a discussion. But the conference goes on week after week, and the patients keep coming back so that gradually a body of knowledge is

built up about them and everyone in the team knows every patient. In this way the whole team operation is unified.

Patients have different relationships with different members of the team. It is important that each member of the team know what every other member is doing. It is the social worker's job to feed in the necessary information. It is my job, as psychiatric consultant, to work in partnership with her so that there is, continually and in regard to every patient, a team plan which is constantly being changed and modified in the light of new experience.

Our social workers go into the home whenever possible. This is of special importance in the post partum period. The social worker is more interested than the other members of the team in the environmental factors.

Miss Rice

I should like to emphasize a few points. One is, that these mothers come to us normally pregnant and supposedly with no known problems. Yet perhaps the very fact they have chosen this clinic indicates they have more needs than they are articulating. We have found, because we have contacts with all mothers, that social and emotional needs are frequent in the group. In other words, most of these mothers do need the help and support of the social worker during this period. I myself would expect this to be true in any prenatal clinic. From the preventive point of view, we need to recognize that the problems exist even though the mothers do not express them or ask for help.

The second point I would like to make has to do with the home visit. We have been reconvinced (and I think it was Dr. Caplan who first urged us to go back and study the patient in his social setting) of the value of the home visit in giving us an entirely different understanding of the woman in her social contacts than we could get in an office interview.

We always make at least one visit during the post partum period before the woman's first trip to the well-baby clinic, because we recognize that this is a traumatic period for her. We have found that a visit at this time helps the mother and also gives the social worker a broader understanding of the mother-child relationships in the triad of father-mother-child.

I should also like to emphasize some of the points Dr. Caplan brought out about the importance of the broader family. That is, we have found, through this group of mothers, that one really cannot think of just father-mother-child, one needs to think of the total family constellation and also of the neighbors who play a part in this woman's adjustment to her problem of being a new mother.

We have found a good many mothers who needed to make a realistic adjustment to giving up a job and becoming a mother. Some of these natural experiences the mother has to go through, but many unnecessary conflicts arise.

We are also attempting to carry on some research. What we will bring out is yet to be determined, but we are in the process of completing what one might call a very complicated schedule. We are trying to get at the question of what the difficulties in the establishment of motherhood are for these women. We hope we may have something for you in the future.

The Stereotype of Home Visiting and the Professional Personality of the Public Health Nurse

Dr. Caplan

The notion that only one person should visit the home and that this should be the public health nurse has a very special meaning, which is related to the professional personality of the public health nurse. The idea may be regarded as troublesome by other people, and usually does trouble other people, but if you think of it merely as a trouble, you are not going to get very far with it. There are many reasons for this notion. You find it all over the world among public health nurses. The fact is that the nurse feels, "This is my family." She is tremendously involved personally with her family, and resents intensely anyone else going in to her preserve.

I think the reason for this is to be found in the attitude nurses have toward public health nursing. Public health nurses have a very hard time of it in many respects. Each of the other specialists in the field, the obstetrician, the pediatrician, the social worker, has a fairly defined, reasonably delimited area in which he is a specialist. But a public health nurse cuts across all these. She knows a little about nutrition. She knows a little about obstetrics, a little about psychiatry, a little about social work. If you think of us moving vertically, she moves horizontally. She knows, however, that she is not a specialist in any of these areas. This places her in a peculiar position professionally. That is one point.

The other point is that, by and large, the nurse is poorly paid and, by and large, has a very hard life. She is out on the beat the whole time. If you go out with any of them, even though they take you to their best places not to their worst, you will find out what a hard time they have. They move around on foot in all kinds of weather. If a nurse works in the lower social and economic areas or in mixed cultural areas, she is going to be an unwelcome

figure in many places. So she does not schedule visits but just drops in. She runs the chance of finding no one at home, but very often when the people are at home, they will not open the door for her. This is especially true of the public health nurse who is doing preventive work. It makes her situation very difficult.

These nurses, working in this field over a period of years, beset by all these difficulties, have to have some kind of satisfaction. They get their satisfaction from a tremendous personal investment in the families they serve. This is the reward for their work, and it can be very rewarding.

Another interesting point is that these nurses usually stay in the same district and know the same families over the years. Some of those working in the Boston Health Department have been in the same district 20 years. They grow old with the work, and come to feel a very strong personal attachment for it, which is not a bad thing from a certain point of view. This enables the public health nurse to have the kind of communication with patients which no one else in the professional field has.

We are on a higher status than a patient, and the public health nurse is on a level with the patient, from the patient's point of view. The public health nurse has developed techniques which allow for free communication, and this in turn prevents the wide separation which exists between other professional workers and their clients.

Add to this the fact that public health nurses do not know how to make written reports. The reason for this is that they do not have to make them and if they did make them no one would read them. There is a peculiar sociological phenomenon in the relationship of the nurse to the public health physician. The public health physician rushes in and rushes out and the nurse knows that if she compiled a report, the public health physician would not read it. She has no incentive to write a report, and she could not even if she wanted to. So over the years the nurse develops a tremendous store of knowledge about these families, and invests them with a considerable amount of personalized energy. She cannot communicate this, and it becomes a private thing of her own.

Under the circumstances, it is easy to understand why she feels that it is an infringement when someone else goes into the home, which is the only place where she is queen. This is the way a psychotherapist feels when anyone else has dealings with his patient which affect the personal, intimate things that go on between him and the patient.

We have not had any trouble of this kind in our Family Health Clinic because there the public health nurse is a member of the team and feels the security of a team member. She also feels the security

of being asked to make reports and of having her reports considered by the other team members as seriously as anyone else's. So far as we are concerned, what the public health nurse has to offer is just as important as what the social worker or the pediatrician has to offer. In fact, the only person on the team who sometimes feels his reports are of little importance is the obstetrician! At practically every conference one or another of them says something like: "I suppose an obstetrician also has something to say in regard to what happens in pregnancy."

Patient Relationship to Team

It is a commonly accepted myth that if 2 people go into a home it is a terrible thing, and if 3 go in it is a calamity. This myth comes from public health nursing. In our work, however, we have one patient attended to by 8 or 9 specialists. This might seem a difficult, bewildering array of people but we have had no real trouble with it. The patients have a relationship to the team as a whole, which is also a relationship to the Family Clinic. The team could leave tomorrow, but the patients would still have a relationship with the Family Clinic.

The patients also have individual relationships with each team member, based partly on the personality of the member and partly on the profession. A patient will see different people at the clinic each day and ask different things from each member of the team. Part of the public health nurse's duty is to act as a liaison, as the integrator of the specialists.

The patient is warned in the beginning that she will be asked questions by different people which may appear similar. She is told that no two people asking the same question will want the same information, that the different professions are looking for different things.

She quickly learns what kind of interests the different professional people have. Overlapping is avoided as much as possible by a preclinic conference in which the woman is given a route sheet. She is not overburdened and matters are arranged so that she does not have too many of the same things happening to her at the same time. There is the 9-month period of pregnancy or a 7-month period of care, during which the different specialists can space out their questions. We have an overall plan for the patient designed to burden her as little as possible. Certainly we try to avoid any obvious duplication. I have yet to find a patient, out of the hundred or so I have seen, who has resented this in any way, except when

the resentment is based upon some fairly obvious transference phenomenon.

The sex of the team members does not seem to make any difference except in regard to such things as easy transference of old relationships. I have never seen a male nutritionist, but assuming you had one, he would probably get along with pregnant women more easily than a female nutritionist, because it would be harder for the woman to transfer a mother stereotype onto him. A man is doubtless very naive about the way women think. I have to ask them all sorts of questions. I have never had a baby. Perhaps this is a good thing since it makes the woman feel she has to explain it to me.

Another point which must not be overlooked is that the general atmosphere of our clinic is such that the patients very rapidly pick up an extremely powerful, positive attachment for the clinic.

There is one more fact which is also very important, namely, that our waiting room has pregnant women and mothers of young babies all mixed together. It is part of the nurse's function and part of the function of the other team members too, to create a clublike atmosphere in that waiting room. The patients become attached not only to the members of the staff, but also to other patients. All of this stimulates a rapidly developing, powerful, positive relationship with the clinic, as though the clinic were a mother person. In fact, we consciously create an atmosphere in the clinic that will make the pregnant women pay attention to the way in which mothering is carried out.

Work With Fathers

I am afraid the Family Clinic has not successfully carried out its policy of having regular contact with fathers. In the majority of cases the father pays at least one visit to the clinic, but that is not enough. Of course, if the social worker makes a home visit, she can make it at a time when the father is present. I do not know of any project which succeeds in getting the whole family. For one thing, we are working with young people who are not very well off; and if you ask such a man to take time from work in order to come to a clinic you are asking a great deal. Moreover a prenatal clinic is a woman's area, and a man feels peculiar when he comes into it. These things may explain the difficulty, but for whatever reason, out of a hundred cases there have been several where we never saw the husband.

In many cases we have not had as much contact as we needed with the husband or with the family. I believe that you cannot

work with families unless you are prepared to work evenings. In the project at the Whittier Street Health Center, called the "Family Guidance Center," our staff works evenings and most of the work is done in the family's home. In that project we have no difficulty, or practically no difficulty, in making contact with the whole family. But unless we are willing to put ourselves out and depart from our existing routines, we will have difficulty in involving the fathers.

Group Instruction

I think that group instruction is a good thing in a prenatal clinic. But under the special circumstances at our particular clinic, where we want to get at certain individual reactions, we avoid the group situation, except the informal group in the waiting room. If we should ever plan another project like this, we might put some group work into it.

CHAPTER VIII

Consultation

Before talking about our techniques of consultation I would like to stress the fact that these are specific techniques which have been developed within a very special framework. We feel that they elucidate some basic principles which apply not only to the technique of mental health consultation, but also to other forms of consultation. But one should beware of generalizing without considerable thought. The technique we are going to discuss is one well defined method. The practitioners are carefully trained in using the method, and one should be wary of taking bits and pieces of it and applying them generally.

Principles of Technique of Mental Health Consultation

The technique of mental health consultation, as we developed it first in Israel and later at Harvard, was worked out primarily for consultants who were psychiatrists, psychologists, or social workers, and consultees who were mainly teachers or child-care workers. Lately, we have been using the same technique in consultation with nurses in a public health center. We have had to make certain modifications which I will speak about later. We have used the method for about 5 years and so have had a reasonable amount of experience with it. We have discovered that we can teach the technique fairly quickly to people who have already had experience either in casework or in psychotherapy. Such people can learn this technique through an in-service training process in about 12 months.

We are talking about a consultation process in which the consultant and the consultee are both professionally trained people. The consultee asks for help in regard to mental health problems that concern the consultee's client. So three people are actually included, the consultant, the consultee, and the client.

This technique was planned to take full advantage of crisis situations. That is to say, it uses the energy of the crisis, and it takes full advantage of the crisis situation, in which the usual

balance of force is teetering. It is used in a particular situation to obtain a maximum effect in a minimum time. The fact that it was planned for crisis situations makes this technique different in many respects from other forms of consultation.

Initiation of the consultation contact

In planning a consultation service, one must first have an organization structure which provides a channel of communication between the potential consultees and their institution on the one hand, and the consultant on the other.

I used to think that it was advisable for the consultant not to be a member of the staff of the consultee institution. I thought that as a staff member he would be influenced by the field of forces within the institution to such an extent that he would be hampered in his role as consultant. But I am no longer sure it is impossible for the consultant to be a member of the staff of the consultee institution.

One who comes in from the outside can be a neutral figure, while a member of the staff must almost certainly be allied with one or another group within the institution. This would hamper a consultant since his work requires him not to have a vested interest in any one aspect of the institution. There is also the possibility that one might be a special kind of staff member and keep himself aloof, but this is an uncomfortable situation to be in. Some men do accomplish this. A minister, for example, in many congregations must go around and listen to the talk of all kinds of people without becoming linked with any one group. But although the consultant might possibly be a member of the staff of the institution, he should under no circumstances hold a position of administrative responsibility in relation to the consultee. This restriction is essential because consultation demands an accepting, noncritical, permissive attitude, which is incompatible with the administrative role.

I think an administrator sometimes makes a mistake in trying to be noncritical. His role requires him to be critical since he is responsible for seeing that a certain level of performance is maintained.

Although it is good for the consultant to be based outside the consultee's institution, he should come inside the institution to carry out his work. Only by penetrating the field can he obtain a first-hand impression of the forces impinging on the consultee and get a valid idea of the difficulties he is facing in his work. The consultee's problem must never be seen in a vacuum. That is, it must not be seen merely in relation to the interplay of his personality

and the immediate difficulty of the client. It must always be seen as something integrally related to the general system of social interpersonal forces in the institution and subject to the culture of the group.

Once a channel of communication has been established, the consultant should come into the consultee's field in response to an invitation based on some need felt by the consultee. Until now our only experience has been with cases where the invitation was voluntarily extended by the consultee. It would be interesting to see whether a workable consultation contact could be initiated compulsorily; for instance, by regulations which demand that certain problems be discussed.

As a matter of fact, we have had a few instances where a school principal has said: "Well, now, we want you to see Mrs. Jones about little Willie," and Mrs. Jones herself has not felt any need to initiate a consultation contact. However, the fact that the principal felt the need means that some need was felt in the institution.

Regulations might be laid down that all children who wet the bed or failed in their school work, for example, must be referred for consultation, but I doubt whether this would work. It certainly would not work from the point of view of a crisis technique. If, for example, we took all children who were bed wetters or who were masturbating, in most cases we would not have teachers in a crisis over these children. We have found that, other things being equal, the most fruitful contact is the one where the consultee is most intensely motivated in calling for help. The greater the consultee's anxiety and emotional disturbance regarding the problem, and the more intense his feeling of urgency, the more auspicious the situation is for a consultation contact. In other words, the more intense the crisis and the more powerful the forces involved, the better chance there is for satisfactory consultation.

This fact has led experienced consultants to prefer to operate in crisis situations, that is, in situations where the consultee's emotional equilibrium and often the emotional equilibrium of the entire institution have been disturbed by contact with the problems of the client. It is this disturbance which hampers the consultee in his handling of the difficulty, and this forms the target of the consultant's intervention.

The consultee rarely has insight into the situation. The only need he feels is for the consultant to direct his attention to the problems of the client and it is for this that the consultee invites his cooperation. If the consultant is to establish a fruitful contact he must at first accept his assignment at its face value and refrain from making his own contradictory ideas explicit. In other words,

if one is invited in to talk about a child, one must talk about the child, even though it is very clear the real reason you have been invited in is that this particular school or school teacher or nursing service or nurse is very upset about something or other.

The consultant should, however, define his function so as to leave himself free to focus later discussions as he wishes. He must leave the door open for future changes. Experience shows that great difficulties await the consultant who argues his way into a field without a clearly expressed invitation from the consultee, based on a felt need of some urgency, or who accepts an invitation which is not motivated by emotional disequilibrium but by politeness, prestige, or curiosity.

Developing and maintaining the consultation contact

The continuing link between consultee and consultant is provided by the emotional relationship which is build up between them. This not only motivates the consultee to maintain the contact but is the vehicle for the consultation process itself. To build up this emotional bond as quickly as possible, and to be constantly aware of its nature, is a basic responsibility of the consultant. Until the relationship is established he should not reduce the anxiety level of the consultee, since in the initial stages this is the force which holds the two together.

This is a very important point. It may surprise you that a psychiatrist would not want to reduce anxiety. But in this situation it is the anxiety which holds the consultee in contact with the consultant, and if the anxiety is reduced the binding force is lost.

In the early stages of the contact reassurance reduces the consultee's felt need, and if he has not yet developed a meaningful emotional relationship with the consultant he may break off the contact. I mean by reassurance a direct lowering of anxiety by techniques of suggestion, such as saying to the consultee, "Well, now, everything's all right." I do not mean the lowering of anxiety which is a secondary consequence of ego support.

On the other hand, the consultant must be tactful and sensitive to the strain under which the consultee is laboring. He must not allow the latter's anxiety level to rise too high, because this may be construed as a rejection, which will then effectively block the development of a positive relationship. In other words, the consultant cannot callously say he does not care whether the consultee is anxious or not.

The technique which is most useful in keeping the consultee's anxiety at an optimum level is to avoid reassurance and get him to

agree to a joint examination and clarification of the problem. The consultant offers his help and support and then "plays for time." This is essential to the technique. The consultant accepts the anxiety of the consultee and says in effect: "This is something I think we really should be anxious about. This is a very complicated problem. I should like to help you, and I intend to help you. Let us examine this together." Then he uses whatever technique seems appropriate in order to put off action, to play for time.

One of the consultant's goals in the first consultation session is to arrange that there shall be a second session. He does this by making it clear at the end of the first consultation session that they are facing a complicated problem which needs to be examined from all angles. By that time some sort of contact has been established and the consultee wants to continue it. It will be clearer in a moment why this is, but if the consultee has the time he will build up an emotional relationship with the consultant. If the consultant accepts the consultee's sense of emergency and offers a solution immediately, no relationship will develop.

In carrying out this maneuver, the consultant must avoid being infected by the consultee's sense of urgency and panic. He must aim at delaying a decision. This may be difficult to do, since this technique is used in crisis periods. People are milling around. They are pressing. They are anxious. They are disturbed. It may be difficult for the consultant to keep his head and not accept as his own the consultee's feeling that this is a burning issue for which he must get an immediate solution.

Experience has shown that the consultant's own lack of anxiety when facing the problem and his promise of support are sufficient to keep the consultee's excitement within manageable limits, as long as the consultant does nothing to weaken the latter's existing defense mechanisms. I will repeat the warning many times about not attacking the defense mechanisms of the consultee.

As in individual psychotherapy, here too the worker must beware of attacking defenses before he has discovered and dealt with the dangers against which the defenses were erected. And this is a difficult matter because not only the consultee's intrapersonal defense mechanisms, but also the defensive structure provided by the culture of his group, must be considered. The consultant's first task after entering the field is to assess the supporting features of the social system. He should avoid any action which may weaken these supports until he can deal with the consequences. For this reason he should allow himself to be received by the consultee and the institution according to their established preconceptions, and should be willing to be manipulated to some extent until he sees

how his own role is being fitted into the preexisting field of forces. The word "manipulation" has unfortunate connotations for the general public, but as a technical term used in discussing role ascription it has no authoritarian implications.

Whenever you move into a new situation people will want you to play a certain role and will arrange things so you do play a certain role. For instance, when you arrive at a school, the principal is likely to say: "We've arranged for you to see the teachers," and take you into a room that is set up as a classroom with benches. The teachers will be sitting in rows and you will be put there as a teacher of the teachers.

You may feel inclined to alter that situation, because you do not want to be an authoritarian figure teaching the teachers. You would like to say, "Don't you think we ought to sit around in a circle?" or something like that. This would be a mistake. Since they have seated you in this manner, set the stage in this way, all this must have some meaning in the defensive structure of that institution. They have put you in this role because that makes them feel safer. This might be because in this setup there is a big distance between you and them, and they are in a group supporting each other. In other words, an arrangement of this kind usually implies a certain amount of anxiety on the part of the people in the institution.

If you were to break through this by altering the arrangement of the room, you would not be accepting the role they ascribed to you, and would therefore be weakening the defenses which they had put up. Until you really know what is going on in the field (and this may take considerable time to find out), it is very important that you allow yourself to be accepted as they want to accept you.

For instance, if you go to a place intending to lead a discussion, and they say: "We want you to give a lecture," then give a lecture, even though you feel that a lecture is a waste of time. If it makes them feel safer, they should have a lecture. There will be a discussion afterwards in which you can do what you want to do. In other words, the consultant must be prepared not only to accept the consultee as a person but also to accept the institution as a social system which has developed its own cultural methods of achieving equilibrium. The latter is often the more difficult task. We're all fairly well trained to accept individuals as people, but we are not as well trained to accept institutions as cultural units in an equally nonjudgmental way.

The consultation process will, almost inevitably, involve an attack on some of the defenses of the consultee and of his social system, but there is no way of telling in advance which defenses

will be dealt with in this way, and in many cases certain defenses will have to be strengthened rather than weakened. It is usually the consultant's own insecurity, his fear that he may be manipulated too far away from his own defined role, that is responsible for mistakes in this area.

The question of how far the consultant should allow himself to be manipulated is a matter that must be decided in each case in light of the consultant's experience and skill. He must always define the limitations and scope of his role in the initial phases of contact, and this definition may have to be repeated frequently.

The way the consultant handles the consultee's attempts at manipulation is an important factor, both in the consultation process itself and in the building up of the relationship. This, of course, is a basic problem in all casework technique. The acceptance by the consultant of the defensive system of the individual and his group as a framework for the cooperative endeavor, his active offer of help and support in handling the problem, and his willingness to understand the nature of the consultee's circumstances without criticism or moral judgment, all facilitate the establishment of a mild positive transference in the consultation relationship. This type of transference has been found, in practice, to be the appropriate link for maintaining the consultation process.

Duration of the consultation contact and its termination

It is an important question whether regular systematic contacts over an indefinite period are to be preferred to occasional consultations or blocks of consultations in response to crises produced by specific problems. There is little doubt that once the channel of communication has been opened between consultee and consultant, it should be kept open in preparation for future crises. In a big institution with many potential consultees, regular visits at set intervals consolidate this link. But it is doubtful whether a prolonged series of interviews with an individual consultee in the absence of crisis situations justifies the time expended.

You must remember that this technique was planned to get the maximum effect from a minimum expenditure of effort by a relatively small group of consultants. It was worked out originally in Israel where we had about eight workers to cover the whole country. Israel is not a very big country but the communication difficulties that exist there make it seem larger than it is. We had 16,000 immigrant children in institutions scattered over the length and breadth of the country. We believed there were about a thousand

potential consultees, and we had eight workers to cover this entire area.

So the technique was worked out with a view to expending consultant effort in the most profitable manner in order to provide total community coverage.

If you have a long series of interviews with an individual consultee, your work is apt to develop into either mental health education or psychotherapy. These are both potentially valuable in their own right, but only if planned for and defined as such. (By mental health education, I mean any educational effort designed to enlarge your subject's knowledge about mental health in general. By psychotherapy, I mean a special type of work dealing directly and explicitly with the intrapersonal difficulties of your subject in an attempt to treat him for a condition he has defined as an illness.)

When offered as a type of consultation, such prolonged contact appears to produce little more than a nonspecific ego support, and may eventually lead to a situation of major dependency of the consultee on the consultant. Only in exceptional cases would this be desirable. I will not say it is never desirable. I think that providing a supportive relationship to someone in a key position who is insecure in regard to his own personality, might be a profitable policy, but only if it had been carefully defined as such in advance.

Experience confirms, over and over again, the importance of the crisis and its consequent emotional disequilibrium in preparing the consultee to benefit from consultation. When his psychic equilibrium has been disturbed by the stimulation of unsolved or precariously solved emotional conflicts as a result of having to deal with similar problems in his client, he enters a state in which he can be drastically affected in a short time by apparently minor manipulations on the part of the consultant. Similar techniques applied at other times, when his emotional life was in stable equilibrium, would have very little effect.

It cannot be said too often, because it is so tremendously important: If you do the same thing at different times, you get different results. Something which seems no more than a superficial patting on the back, and which would be no more than that usually, if applied at a moment of crisis may produce a drastic change in the mental economy of the consultee. It follows that the consultant should delay his intervention until the crucial moment of crisis. Premature action is as much to be avoided as undue delay. This suggests the analogy of the surgeon who incises an abscess at the moment it points. At just that moment, he gives a nick and out the pus comes.

In regular contacts over long periods, the consultant should avoid "nipping in the bud" developing crises and thus losing their energizing force. In psychoanalysis the skill of the analyst shows in his judgment of the appropriate moment for making his interpretation. Similarly the experienced consultant learns at what point to intervene. In other words, when he sees a little crisis, he waits until it gets a bit bigger, but he does not wait too long.

It would appear to be good policy to terminate a consultation contact as soon as the problems associated with the individual crisis have been resolved. However, the termination should not be final. It should be regarded as an interruption in a chain. The channel of communication should be left open, so that when further trouble arises, as it is likely to do, the contact can be renewed.

This process is in contrast to accepted policies in education and psychotherapy, where an attempt is made to deal systematically with a more or less complete subject, so that a more or less definite termination can be arrived at. In consultation, such a systematic approach is hard to envisage, since the process deals with narrow segments of the consultee's total range of problems which have been accidentally activated by his present-day experience. It can be expected that after a sufficient number of contacts, the range of segments likely to be activated by routine professional experience will have been covered, after which there will probably be no need for further consultation. In this respect, consultation differs from the usual type of long-term supportive therapy, where an ego-bolstering process has to be continued indefinitely.

To sum up—we have, on the one hand, psychotherapy or education, in which we attempt to cover a whole subject and on the other hand, long-term supportive psychotherapy in which we may go on indefinitely simply bolstering the ego. Between these we have this particular mental health consultation technique. Here we rely on the fact that the consultee has a number of unsolved problems and that as time passes one problem after another is likely to be stimulated and set off by what is happening in his institution or among his clients. Each time the consultant moves in and deals with the particular problem that has been activated.

The question is, how does one know that anything more than bolstering is accomplished. The answer is simple. If you have given successful consultation service in regard to any of these problems, cases of exactly that kind will not be referred again by that person. That is, a consultee will continue to spark off about a particular problem only as long as it is unsolved; if it has been solved it will at least be different problems that come to the surface next time. For instance, if a teacher refers a boy whom she stereotypes

as being an aggressive little ruffian, and you deal with that, and 3 months later she again refers an aggressive little ruffian, you know you did not do the job properly the first time and try again. You can always try again and again until you hit the nail on the head.

If a teacher refers an aggressive little ruffian, and in 3 months' time again refers an aggressive little ruffian, you know this is her stereotype. If subsequently she never refers an aggressive little ruffian, but refers a masturbator or a child who is slow in learning, you know that you have dealt with the first problem, that she is now able to handle problems of aggression in children because similar problems in herself have been to some extent satisfactorily dealt with. So it is no longer aggression that pulls the trigger for her. But she may have other problems which may now be triggered off.

Ends and means

The goal of consultation is to achieve a free emotional relationship between the consultee and his client, so that the consultee can be as sensitive to the client's needs as his native capacities and acquired knowledge allow, and so that he can react to those needs unhampered by tensions derived from his own emotional conflicts.

This type of consultation does not have the goal of increasing the consultee's knowledge about emotional life or mental health. It does not have the goal of increasing his professional skill. Its one goal is to allow the consultee to make the maximum use of his professional skill undisturbed and unhampered by the various unsolved problems in his own personality.

The technique aims at maintaining or increasing the psychological closeness of the consultee and his client by helping the consultee to become more comfortable in this human relationship. This is similar to the mother-child relationship, and a similar philosophy is applicable. We want to enable the teacher or nurse to be close to her client or patient.

This procedure is in marked contrast with certain other approaches which increase professional distance by providing the worker with additional techniques. Professionalization normally increases the distance between the professional person and the client, whereas what we are aiming at in this mental health consultation technique is to decrease the distance. It is well known that a nurse or a teacher, say, who has a close contact with most of her patients or pupils increases the distance between herself and them when she gets upset. She turns her head aside and looks the other way. What we want to do in mental health consultation is to bring her closer

to her client, so that she can go on using her ordinary techniques as a teacher or a nurse and also have a more comfortable human relationship with the person she is dealing with. This is a most important factor in dealing with the mental health problems of the client.

Consultation attempts to achieve these ends by providing a solution for the kinds of problems which most frequently underlie tensions in the consultee-client relationship. As indicated previously, these are usually due to upsets in the consultee's emotional equilibrium.

The fact that the consultee is thrown into disequilibrium by the problems of the client results in various disturbances in his professional capacity to handle the case. His perception of the client becomes abnormally colored from within himself.

Very often he perceives the client not as a human being in difficulty, but as a stereotype of his own emotional problem, to which he may react by anxiety, excessive blame, oversolicitude, punishing rejection, or other inappropriate responses. This is very like the disturbed mother-child relationship where the mother does not perceive the child as an individual, but as a symbol of her uncle or her grandmother or of her own aggression, or her own sex, or something else.

In addition to attempting this vicarious solution of his problems by projection and displacement onto the client, the consultee may be suffering from anxiety and guilt consequent upon the upset of his own equilibrium. This brings on increased ego burdens, and these unpleasant feelings may act in a nonspecific manner to lower the executive functions of his ego. In other words, the nonspecific emotional upset may make a professional person less effective in dealing with the particular problem that brought on the upset. When people become ineffective in dealing with problems, then in greater or lesser degree depending upon the culture of the institution in which they work, they begin to feel ashamed or guilty or afraid of their supervisors cracking down on them, and very often with cause. So the actual difficulties facing them are then compounded by an ego weakening with secondary feelings of shame and guilt.

Consultation attacks this problem by first offering the consultee an ego-supportive relationship with the consultant. This access of strength may sometimes be sufficient to tip the balance, but this is rare. The strain on the consultee's ego is also reduced, since the building up of the consultation relationship allows the consultant to take on the meaning of an external superego figure.

In addition the consultee's superego-ego tension may be slightly reduced by the consultant's milder reaction to the moral implica-

tions of the problem, and by a certain amount of identification which may occur during the contact. That is, the consultee may feel very guilty about his ineffectiveness, even though he has a very mild-tempered boss. The administrator in charge may be as kind and permissive as anyone could ask, or kinder even, and yet the consultee may feel very guilty because what makes him feel guilty is not an external pressure but his own internalized controls which are wielding a big whip on him at that moment. Tension of this kind can be reduced if the consultant is accepted by the consultee as a superego figure. He is taken in, as it were, into this internalized control system, and the control system becomes milder.

The actual steps in the consultation process are more specific than this, however. They consist in dissipating the consultee's stereotyped perception of the client, and then supporting him while he deals with the latter's human problems.

Dissipation of the stereotype is the name given to a process whereby the consultant, in his role of accessory ego, acts as an emotional bridge between consultee and client, so that the former has an opportunity of rediscovering the latter and perceiving him anew as a human being who is struggling with human problems rather than as a stereotype of "neurosis," "aggression," "sexual perversion," and so forth. This is very similar to the pediatrician who lends her eyes and ears to the mother so that the mother can perceive the baby as a separate individual with its own needs. In the dissipation of the stereotype the consultant at a certain stage also acts for the consultee in just this way.

The next step is for the consultant to support the consultee while the latter offers to the client a helping hand in his difficulties. This almost always alleviates the client's problems to some extent. Since the client's problems are meaningfully linked to the consultee's own difficulties, his solution of them "once removed" in the person of the client often leads to a healthier adjustment of his own internal balance of forces. The solution in the external world is introjected and lowers his own inner tension. In other words, the very mechanism which caused his upset in relation to the client's failure, helps him in reverse to get vicarious benefit from his client's success.

The consultant helps the consultee to solve the mental health problem of his client, by helping him to see the client as a human being. As long as he sees the client as a stereotype he will be unable to help him, because the stereotype has a special meaning in regard to a problem of his own which he cannot solve. When he sees his client as a human being he acts like a human being. However little professional skill he may have, one human being can always help

another human being, so therefore the consultee now helps his client to some extent. When he does this, it has a reflective meaning for himself. He masters his own problem by helping the client who has a similar one. This reflective effect then lowers the tension in regard to his own internalized problem.

To repeat, we have the consultant, the consultee, and the client. The consultee has personal problems which have become linked with the client's problems. He is actually discussing them with the consultant while he is talking about the client's problems. If he ultimately helps the client, this will reflect back on himself and the consultee too will be helped.

The combination of these specific and nonspecific measures leads, in a favorable case, to a new equilibrium in the psychic economy of the consultee, which may be healthier than his previous equilibrium. It may have a stability of its own independent of the continuation of the consultation relationship, which was a temporary measure applied when the balance was in motion. In other words, the effects you get by the consultation process, if you do get effects, may be quite stable.

Obviously the fate of this whole process depends on quantitative factors in the dynamic economy of the consultee. At present, we do not have the necessary theoretical knowledge, and as a rule cannot get enough information about the consultee's personality, to make a prior assessment of the forces on each side of the balance. It is therefore impossible to know ahead of time whether, or in what degree, this method will succeed in any particular instance. But it does succeed in many cases, which is surprising considering the speed of the process and the relatively minor effort involved.

Technical maneuvers

We are now in a position to discuss the actual, technical maneuvers involved in this mental health consultation technique.

Assessment of the problem situation.—One of the first tasks of the consultant is to assess the meaning of the client's problem in terms of the emotional life of the consultee, and of his institution. He does this mainly through a sensitive awareness of the pattern of emotional forces among the relevant parties in the here-and-now situation of his visit. He relies, for the most part, on his observations and interpretation of small items of behavior, which he regards as cues for underlying attitudes, and upon his introspective awareness of his own emotional reactions as they are stimulated by the environmental pressures. The consultant uses himself and his own feelings as a technical instrument.

This type of process is familiar to analytic group psychotherapists, and stands in marked contrast to the method of psychodynamic assessment based on history taking. Any method based upon history taking would be inapplicable to the type of consultation we are discussing, for very many reasons. Among these are the need for speed, and the interference which such a method would create in the rapid building up of the desired consultant-consultee relationship.

However, the consultant here has been invited to deal with the problem of the client and is usually expected to take a history of the client's case. He should certainly do this. But, although some general questions about the consultee and the institution are to be expected, the kind of searching investigation needed to make a psychodynamic formulation would arouse resistance. A few open-ended questions during the progress of the discussions are in order and may yield information about doubtful points. But the consultant's understanding of the situation must depend upon his observations of behavior rather than on an analysis of consultee statements, although the latter may be quite valuable too,

In other words, in this situation you find out what is going on by watching these tiny cues of interpersonal behavior. You must also watch your own feelings because you are part of that field of forces. If you feel anxious you know there are things in the situation which are anxiety-promoting. If you feel angry you know you have been ascribed a role which has something to do with hostility in the situation.

Important insights can usually be derived from an analysis of the way in which the client and the consultant are being manipulated by the consultee and his institution. There is a theoretical basis for this. John Rickman of London²⁰ conceives of personality, from a certain point of view, as a sort of internalized society. As a result of our interpersonal contacts throughout life, according to Rickman, we have taken into ourselves a sort of internal society which mirrors in some way the external society that we have experienced all through our lives. If we have unsolved problems, especially in regard to the significant people in our external society, these will be mirrored in our internalized society by what he calls an incomplete closure of the circuits. People often try to solve their internalized problems by arranging the people around them so that they will play certain roles which can then be introjected, in this way producing what Rickman calls a Gestalt closure.

²⁰ John Rickman: *Selected Contributions to Psycho-analysis*. Basic classes in psychiatry. New York: Basic Books, 1957. 411 pp.

This can be seen very clearly with hysterics, but other people, too, are continually arranging the people around them to act certain parts. The reason they do this again and again is that having these parts acted out in the outside world gives some relief to their internal problems. If the consultant watches very carefully how the consultee sets the stage and what roles he ascribes to different people, including the client and the consultant, he will get some idea of what this internal problem is that the consultee is suffering from because it has not been solved. It is like solving a charade.

The upheaval of the crisis may result in a temporary exaggeration of this tendency to manipulate, at least in the type of cases dealt with in consultation. For this reason it is especially useful for the consultant to present himself at this time as a willing subject for manipulation. In other words, the consultant says: "Take me and do what you want with me." In the same way, a psychoanalyst sits behind his patient and allows the patient to transfer on to him various role models which come from the patient's past. In consultation this is not done in verbal terms but in acting out. The consultant allows himself to be moved around in the field by those who expect him to fulfill a certain role.

The delay which the consultant imposes in the initial stages of consultation not only gives him time to assess the nature of the problems, but also provides the consultee a suitable opportunity to manipulate him. The kind of manipulation we are speaking about here differs from the Machiavellian type of manipulation in that the latter is a conscious process whereby someone expects to gain by making other people do certain things, whereas the former is unconscious.

However, the consultant must safeguard the building up of the desired positive relationship by dealing with the consultee's feelings of disappointment and rejection at this delay. He must also be prepared to handle the frustration caused by his eventual refusal to fit completely into the role assigned him by the consultee's manipulative needs. In other words, the consultant is not going to produce a Gestalt closure. He is not going to be the person the consultee wants him to be. He only moves in that direction until he finds out what the consultee wants of him.

In trying to localize the main sensitivity of the consultee in his relations with his client, the consultant proceeds in somewhat the same manner as a surgeon. The surgeon, in trying to localize an abscess, carries out palpation of the surrounding area, and relies to some extent on the patient's increasing gradient of pain as he approaches the site from different directions. He moves in one direction and finds the pain increasing and knows he has one

boundary. Then he goes around this and finds another boundary, until he knows where the abscess actually is. This will serve as an illustration of the consultation process. In listening to the consultee's story, the consultant should be on the lookout for signs of increasing emotional upset as various aspects of the case are discussed. He may then test out his tentative diagnosis by leading back to these "hot spots" from different points.

The assessment derived from this process will be expressed in macroscopic terms and will indicate the consultee's basic and fundamental needs as well as those of his institution, insofar as these are expressed in the difficulties with the client. It will also indicate the strengths and positive qualities, of both the consultee and his culture, which can be exploited in solving the problem.

Experience shows that the microscopic diagnoses needed in psychotherapy are not necessary for effective consultation, which operates in the manner of a shotgun rather than with the rifle precision of direct psychotherapy. In consultation we deal with fundamental things: relations toward aggression, toward sex, toward discipline, toward achievement. These are fundamental and gross things, which can be dealt with very effectively by a shotgun technique.

Building up and maintaining the consultation relationship.—The principles and techniques used in building up the mild, positive transference of the consultation relationship are familiar in casework practice. The consultant's expressed attitudes to the consultee are of prime importance. He should show him the respect due from one professional person to another, and should avoid the development of too dependent or regressive a relationship by placing a continual tacit stress on the consultee's responsible adult status. The consultant should avoid as much as possible being manipulated into a God-like, omnipotent role, and should maintain a modest and nonauthoritarian manner.

On the other hand, the consultant should be outspoken in his offers of help within the limits of his professional role, and should give practical demonstration of his good intentions by his patient efforts at clarification and understanding of the consultee's difficulties. Needless to say, he should make his fundamental attitude of acceptance and absence of moral criticism obvious from the beginning.

All this must be quite obvious to anyone with experience in casework or psychotherapy. However, people who have had experience in psychotherapy and casework sometimes have difficulty in extending these attitudes to the consultee's institution. Possibly their own cultural prejudices have not been as adequately remedied

by their past training as have their individual psychological blind spots. In our training, whether as social workers or psychiatrists or psychotherapists, insufficient attention is paid to cultural blind spots. By and large we are much less able to be unbiased in the acceptance of cultural differences than we are in the acceptance of individual, psychological differences.

We have already spoken about avoiding negative relationships by being careful not to attack the individual defense mechanisms of the consultee. This may mean that the consultant will have to accept the role of lecturer, or advice giver, or something else undesirable from his point of view, until he has built up the relationship with the consultee. At this stage he is supporting the ego structure of the consultee and preparing him for the fact that the consultant does not fit completely into the ascribed role.

This illustrates the importance of the time sequence in the consultation process. While the positive relationship is being built up, the consultant should avoid any maneuver which might have a negative influence on the consultee, but once this link has been established the consultee will be able to rely on the relationship for support and so can bear increasingly more anxiety and frustration. That is, in building up the relationship the consultant accepts to some extent the role assigned him. By the time he decides to reject the role, he already has a good relationship with the consultee and this has so strengthened the consultee that he does not need to effect a Gestalt closure by manipulating the consultant.

As in casework practice, the consultant should be on the lookout for evidence of doubts and for negative feelings toward him on the part of the consultee. He should reduce the latter's guilts by encouraging their open expression. He should be on the alert for signs of these negative feelings being acted out by displacement toward the client or toward other people in the consultee's environment. When this occurs he should actively help the consultee to verbalize his suppressed attitudes about the consultation. It is almost the rule that the way in which the consultee feels about the consultant will be transferred to his dealings with the client. Therefore, if the consultee begins to deal negatively with his client, it is reasonably certain that some negative aspect of the relationship between the consultee and the consultant has not been verbalized and is being transferred to the client.

The method as described here only rarely leads to overdependent and regressive transferences. But if such unwelcome attitudes do develop they can be controlled by such usual techniques as switching to a more didactic and intellectual approach, or by increasing

the intervals between consultations. It is important to avoid a too dependent transference.

Ego-supportive techniques.—Ego support comes as a consequence of the emotional relationship between the consultee and the consultant. Little need be said concerning specific technical procedures. The usual methods of casework and psychotherapy are equally applicable here.

It should be mentioned, however, that the consultant makes a special point of searching for the strengths and positive qualities in the personality of the consultee and in the culture of the institution and throws the weight of his appreciation behind them. The consultant should not spare words of praise, but these should be sincere and directed to real elements of value in the situation. Empty compliments have a way of producing negative effects.

Another source of support for the consultee is the consultant's lack of anxiety in his discussion of the aspects of the case which have been frightening the consultee. This is in sharp contrast to the ego-weakening effect of lowering the consultee's anxiety level by reassurance, a procedure which attacks his adult status. This point needs to be developed further.

There are two ways of lowering anxiety, one of which we may call reassurance. This is the technique usually employed by nurses, pediatricians, general practitioners, and sometimes even by psychiatrists and social workers. Here you rely upon the high prestige value of the worker as seen through the eyes of the subject. You have a parent-child type of relationship and the worker, speaking as the parent says: "There, there. Everything's all right. I'll kiss it better." This is suggestion. It is an effective technique. It will reduce anxiety, assuming the person being dealt with believes in the worker and feels that he is a good and powerful person. Such reassurance may reduce anxiety, but it may do something else, too. It may reduce the ego strength of the client if while reducing anxiety one is also reducing his adult status and putting him in a dependent role.

This technique should usually be avoided, but not always. For instance, under disaster conditions, after a tornado, or at any time of great stress, when one must work quickly and with very distraught people, this is the technique to apply. When people have been shocked by the traumatic events of a catastrophe, one does not have to be afraid of making them dependent. They are already dependent.

But ordinarily this is a technique to be avoided. Instead anxiety should be reduced by increasing the ego strength of the subject. This is done by lending him a shoulder, by saying: "Well, now,

you're a grownup adult person. I'm no bigger than you, but I've got a shoulder. We'll work together on this." In practice, this is done by discussing his problems with him, and understanding his problems. The client learns that the worker is not anxious, and introjects the worker into himself, as it were. He takes the worker in and becomes bigger, whereas with the previous technique he becomes smaller. And as he becomes bigger he becomes less anxious.

The consultant should aim at being accepted as a strong person who understands and is willing to stand by the consultee while the latter is dealing with his problem. By not taking over himself, the consultant expresses confidence in the ability of the consultee to handle the affair successfully. This is a significant part of the ego-supportive technique.

Relaxation of superego pressure.—There is another technique which might be called the relaxation of superego pressure. The consultant presents himself to the consultee not only as an accessory ego figure, but also as an additional superego and ego-ideal figure, with whom the consultee can identify himself. The consultant should try to make his nonjudgmental attitudes felt, especially in those areas where the consultee feels most tension and guilt. This is most effectively done in a discussion which ostensibly focuses on the client. The consultant uses a kind of "double talk." He is really discussing the consultee, but he pretends not to know this.

Some people may consider this hypocritical, but one can look on it as directed tact. It is tactful, if a lady asks you what you think of her hat, to say: "You look very nice," even though you have certain reservations about the hat. You do not express them. Also, you do feel that it is quite an interesting hat. So you do not have to tell a lie. So far as our double talk goes, the consultee could, if he wished, make certain things explicit and the consultant is merely conceding to the wishes of the consultee to keep certain things unsaid.

It is important for the consultant to help the consultee to verbalize and to discuss topics about which he feels ashamed and guilty. The consultant should help him to understand and accept the naturalness of such unpleasant reactions. But he should discuss these problems in terms of the client not in terms of the consultee. The consultee can talk freely about his problems as long as he is talking about them in terms of the client. Usually the consultee is unaware of what he is doing.

We said earlier that the consultant's lack of anxiety was an important factor in ego support. In superego relaxation, the crux of the matter is the consultant's lack of blame. This is similar to the technique, which we discussed earlier, for dealing with failed

attempts at abortion. There the technique consisted in allowing the mother to talk about her terrible sin and to feel that the worker did not blame her. Nor did he exonerate her from blame. He did not say: "You've done a good thing in trying to terminate this pregnancy." But nor did he say: "You are a terrible, horrible monster of a person."

The consultant also acts as an ego-ideal figure in demonstrating to the consultee his relaxed and humanly understanding attitude, both to him and to the client. Here again, the consultee may identify himself with the consultant. The consultant should be aware that this is likely to happen and keep his behavior in the consultation setting in line with the behavior he wants the consultee to show toward the client. The consultant must remind himself: "My attitudes toward the client are going to be taken over by the consultee. If I'm relaxed and understanding in regard to how this child behaves, I don't have to say to the consultee, 'You should be like me.' The consultee will pick that up." So you have to be quite careful that your behavior and your expressed attitudes are such that you would want them to be picked up by the consultee.

Many psychologists and psychiatrists would behave very differently here. A psychologist might want to carry out some kind of psychological investigation of the client or have certain psychotherapeutic things done for him. If attitudes of this kind are expressed to the consultee, he suddenly begins to act as a psychotherapist to the client, which you very much want to avoid. You want the nurse to continue to be a nurse, and the teacher to continue to be a teacher. You want the teacher to be a teacher with a more free, human understanding of her pupils, not a psychologist or a caseworker or a psychiatrist. The attitudes expressed by the consultant should be the attitudes he would like the consultee to express to the client.

This is a place where one must avoid all jargon, and all kinds of intellectual and technical investigations and analyses. This is hard to avoid because it is just what the consultee expects from the consultant. She thinks: "Here comes the professor who is going to analyze the situation by some magic." If the professor does this, the consultee is pleased; but when he comes back the next time he will find that the consultant has become a little professor of psychiatry.

Dissipating the stereotype.—Now we come to the crux of the whole process, which is dissipating the stereotype. This technical maneuver is possible only after the consultation relationship has been properly developed and the consultant has become established as an ego and ego-ideal figure. Time relations are very important here. Con-

sultants who are just learning the technique very often attempt to rush this, and it cannot be rushed. The consultant must wait until he is established as an ego and ego-ideal figure. Then he can dissipate the stereotype, but not before.

At this stage the consultant begins to draw the attention of the consultee to the individual human characteristics of the client, either during joint observation of the latter's activities or in a subsequent discussion. He may do this, for example, by sitting in the classroom with the teacher and watching the child and talking with the teacher afterward; or, with nurses, by going with them on home visits. This teaches him something about the actual life of the nurse, as well as allowing him to carry out the maneuver. In this way, the consultee is involved in a joint search for the special, human meaning of the client's reactions. During the discussion the consultant first puts forward his own personal perceptions of the client, and little by little encourages the consultee to do likewise. The consultant takes care to use the consultee's language as much as possible and avoids his own professional jargon, since his aim is to promote the psychological closeness of the consultee and the client.

In the cases where this maneuver is successful—it sometimes takes a few interviews to accomplish—the consultant becomes aware of sudden and dramatic change in the consultee's manner. Many workers say that a kind of click occurs and suddenly the consultee's perception changes. Sometimes this "click" is accompanied by expressions of surprise on the part of the consultee, similar to the feelings expressed by an analyst after a mutative interpretation as described by Strachey.²¹ The same thing occurs in certain disturbances of the mother-child relationship. The mother has been looking at the child as a stereotype, and then, at about the fourth or fifth interview, will suddenly say with surprise: "But think of it! My child is like that and I never realized it before."

Some of these stereotypes are grotesques. For instance, I remember one case in a village in Israel. The consultee, who was the head of the institution, complained about a mentally defective child, a little girl, and said: "She can't learn. She's been here a year and she hasn't learned any Hebrew. I want you to remove her. She's spoiling the other children."

I asked him: "What does she look like?" and he hesitated. I thought this a bit strange; after all, he saw the child every day. But he found it difficult to describe her. He finally said: "She's little and got a dark, blotchy skin covered with pimples, and she's very untidy."

²¹ James Strachey: The nature of the therapeutic action of psychoanalysis. *J. Psychoanal.*, 15:130, 1934.

I saw the child, and she was a lovely little girl! She had light hair and she certainly wasn't mentally defective. Her I. Q. was somewhere around a hundred and fifteen. This man had seen the child every day but he had been perceiving something quite different. He had been perceiving his stereotype of a mental defective. This was partly made up of the appearance of the girl the first time he saw her, which was after she had traveled for a week across the Mediterranean in the hold of a boat. The pimples he thought he saw may have had something to do with the common superstition that people who masturbate get pimples and become mentally defective.

The teacher had been looking at this child every day and not seeing her, but it was very easy to get him to see the reality in this case. One day he suddenly said: "You know, this girl has had a very hard time because, now I come to think of it, the other children in the class all spoke English, and I used English in order to teach them Hebrew. This little girl couldn't speak English. She must have had a very hard time. No wonder she couldn't learn Hebrew. And if she couldn't learn Hebrew, it would be very difficult for her in the other classes because we carry on all our classes in Hebrew."

He now saw a little human being with problems, and immediately he began to work, not as a psychotherapist but as a human being, to solve the little girl's problem. Of course the situation had a specific meaning for him. He was a highly intellectual fellow who drove himself to get very high results from his class, afraid the whole time that his results would not come up to the expectations of his superiors. To him the worst calamity imaginable would be to have a dull pupil who would prove that he was not as good as he should be.

What he was able to see, as a result of trying to help the child, was, first of all, that dullness is no crime. It had ceased to be something related to masturbation or whatever his fantasy as a child had been which accounted for dullness. It is a matter of trying; a matter of certain obstacles which one could deal with more or less. In all this there were individual characteristics, which had meaning for him, and he was finally able to say to himself, as it were, "People should expect me also to be a human being." In point of fact, although his superiors were forcing him to get as high results as possible, they were not forcing him to the extent he imagined. Finally, his perception of the child and of himself had altered enough for him to see the child realistically and therefore, reflexively, to handle the same problem in himself.

Techniques for avoiding psychotherapy.—The avoidance of psychotherapy is one of the objectives of this consultation service. The personal implications of the consultee's difficulties in his work are recognized but the latter, and not his intra-psychic conflicts, are the focus of the process.

Throughout the consultation contact it is made clear implicitly, and if necessary explicitly, that the consultant's role does not include handling the private personality problems of the consultee. No attempt is made to deny the existence of such problems, but if they are brought up by the consultee the consultant explains that they cannot be dealt with in this context. He expresses his belief that, whatever the nature of his difficulties, the consultee can control them to the extent that they do not interfere with his handling the client's problem. This is one of the great fears of the consultee. When he is in crisis or when he is upset, regardless of how much awareness he has of his problems, he is afraid that his own problems are upsetting his work as a professional person. And indeed they are. But he is afraid that they are certain to upset his work. And that is not true. A man's personal difficulties need not necessarily be linked with his professional achievement.

If it seems necessary, the consultant may offer to refer the consultee to another institution for psychotherapeutic service. Such referral should not be made until it is seen that the help derived by the consultee from the consultation process is ineffective in quieting his anxieties. As a matter of fact, we practically never make such an offer. We practically never suggest psychotherapy, because to do so implies to some extent that we think the individual's personal problems can be dealt with only by psychotherapy. Actually, most people can deal with their personal problems, given a certain amount of help from care-taking agents and from the consultation process, without having to go to a psychiatrist and lie on a couch for 3 or 4 years.

Of course, for a small number of people psychotherapy is necessary, in fact essential, and there are other cases where it is the easiest solution. But personal problems can be worked out in real life. It is a myth, which many of us have accepted without enough criticism, that psychotherapy is the solution for all ills. It is fortunate that psychotherapy is not the only solution for our ills, since we could never afford the psychotherapists that would be needed to solve even a small proportion of them.

The consultant takes the attitude that everyone has intra-psychic conflicts, and that the usual way of dealing with them is by working through them in real life. If this process fails, there are facilities for psychotherapy and psychoanalysis to which a

person may turn for help if he is sufficiently motivated. We do not need to prescribe psychotherapy, since no one who wants it needs a consultant to tell him where to go.

It is sometimes difficult to avoid dealing with a consultee's request for help with his own problems, without making him feel that he is being rejected, a situation which would damage his positive relationship with the consultant. After the consultant has built up a good relationship, the consultee may decide he wants him to be his psychotherapist. The consultant cannot allow this. He avoids it by turning attention back onto the consultee-client relationship and emphasizing the fact that the consultee's experience with problems in his own personality has probably developed sensitivities and strengths in him which he may capitalize in the service of his client.

For example, suppose that a consultant is dealing with a teacher, about a child with a bed-wetting problem, and the teacher says: "You know, my child wets the bed. I've had a lot of trouble with my child wetting the bed." He does not let her then go on to tell him about that if he can possibly stop her. Instead, he says: "I'm sure if you've had a lot of trouble this way, it will make you much more sensitive to the problems of this pupil of yours and will help you to be more interested in this problem, and you will probably be much better as a teacher in this situation." In other words, the consultant makes an interpretation on the strengths of the situation and not on its weaknesses, and does not allow the situation to develop to the point where she starts asking for help with her own child who is a bed-wetter, or for her feelings of guilt because she has contributed to that.

When the consultee raises questions about his own problems, it is usually because he is afraid that they are interfering with his job. The consultant stresses the positive aspects of the situation, indicating that the consultee, like everyone else, is entitled to have emotional symptoms and need not feel ashamed or guilty about them. Instead of accepting the consultee's invitation to analyze and attack his symptoms, the consultant tries to get him to be more tolerant of them, and tries to strengthen rather than weaken his neurotic defenses.

In most cases the consultee does not bring up his intrapersonal problems, since the consultation process is so obviously focused on the interpersonal relationship between him and his client and on the latter's personal difficulties. It is this focus that makes the process so safe and avoids the resistances which are an inevitable consequence of the psychotherapeutic process. Because of this focus, no attempt is made to give the consultee insight into what

has been happening in respect to his own difficulties or into the consultation which has resolved them. Such insight might be supposed to stabilize the results of consultation but it may also have the undesirable result of making the consultee afraid to involve himself in the future with clients and consultants who may trigger off his unsolved conflicts and disturb his psychic equilibrium. The consultant does not have to let the consultee into the whole story of what is going on, because in this situation he is an expert. And the essential point in the role of the expert is that the expert, in dealing with the client, is paid by the client or by the community to have better and wider knowledge of what is going on than the client, and to keep that knowledge to himself.

I do not know whether any of you have read Sullivan's book. *The Psychiatric Interview* by Harry S. Sullivan,²² contains a very interesting essay on the importance of the expert role of the psychiatric interviewer, in which this point is made very well.

After a number of successful consultations, the consultee will develop greater tolerance for emotional expressions in himself and his clients, but this rarely amounts to real insight into what is happening to him in any specific case.

In conclusion, from a practical point of view, the importance of avoiding psychotherapy is that this allows consultation to operate with a minimum arousal of resistance and at maximum speed; and although its results are not as far-reaching as those in psychotherapy, they are often quite stable in the narrow segments with which consultation deals. It is this which makes consultation appropriate in the context of a preventive program. No community can ever provide enough psychotherapists to handle more than a tiny proportion of its members who have inadequately solved emotional conflicts. For this reason if for no other, mental health programs should be as sparing as possible in the use of psychotherapy.

Use of Crisis Technique

We may now ask how far the principles worked out in our particular consultation service are actually specific. Do some of them apply across the board? Can they be used to help people doing consultation to become more aware of what they are doing or to communicate what they are doing to other people? Can they help us to distinguish the different types of consultation which different people are giving?

²² Harry S. Sullivan: *The Psychiatric Interview*. New York: Norton, 1954. 246 pp.

Epidemiological approach to psychiatry

It is important to distinguish a psychiatric emergency from the emotional upset of a crisis situation such as we have been talking about. A psychiatric disturbance, either in an individual or in a number of individuals, occurs as the end result of a succession of changes brought about by various pathogenic forces. If we examine the succession of changes which eventually leads to psychiatric disturbance we usually find that the individual has passed through a series of crisis situations. In each of these there has been an emotional upset. In each the individual has made a maladaptive response or his family, or his coworkers or some other group of which he is a member, has dealt with the problem in a way inimical to the mental health of that individual.

In a preventive mental health program we do not want to wait until we have a psychiatric disturbance and then treat it. We want to begin further back in the path of etiology. Now the stopping places on this path are the crisis situations we have been talking about. If one acts in response to the crisis situations and helps the individual adapt in a healthy way to these particular problems, he will also be helped toward a line of development which leads to mental health. This gives us what might be called an epidemiological approach to psychiatry. We look for the factors which cases have in common rather than their individual features. We find that there are certain focal points, certain hazardous life situations, such as birth, or role transition, or death, or entering school, a new job, someone becoming ill in the family, or a premature baby, which are continually cropping up. They cannot be prevented. But the important thing about them is the way in which people deal with these problems. People are likely to be in crisis when they deal with these problems. Therefore, crises are the places where we should focus our efforts. In this way we find the people who are upset but not yet psychiatrically ill. It may take ten or a dozen crises, each solved in a maladaptive way, to produce a true psychiatric disturbance.

The question arises, how do we know that the techniques we are using are actually effective? I must admit that I have no idea how one would set about making an evaluation of a program such as this. But that leaves our program in a class with a good many others. I have yet to see any program that will bear scientific scrutiny for evaluating casework, or social work generally, or, for that matter, psychotherapy. However, we do have certain clinical impressions. These are that when you help people to take the right path and follow them up later, they seem to be moving in the right

direction; and when you do not help people to take the right path, they may often move in a wrong direction.

Take the cases of failed abortion for example. Women who attempt to abort and fail and do not get help with their guilt feelings at that time, do develop disturbed relationships with their children. On the other hand, where we were able to step in early and deal with the situation, the women did not develop that particular type of disturbance.

Types of cases referred to consultant

The consultant must always bear in mind that he doesn't carry the baby for the consultee; that is, the client continues to be the responsibility of the consultee. The consultant does not take the client from the consultee.

We are speaking, of course, of clients who can be handled by the consultee and not about clients who are so disturbed that they require referral to a specialized agency. Most of the children who are referred, on objective investigation by a psychologist or a psychiatrist are found not to be seriously disturbed at all, and do not need any specialized service. These form the majority of the cases referred by teachers for consultation. There will be a few cases which no teacher could be expected to handle. But even in these, before the consultant makes an actual referral to a psychiatric or remedial agency, he would be well advised to work through the implications which the situation has for the teacher.

Sometimes the best consultation service will result in the teacher making a referral. A teacher may have a pupil with a clear psychiatric disturbance and not refer the child to a psychiatrist because she herself is emotionally involved in the situation.

Nurses often have difficulty in communicating with outside agencies. The social structure in which she works may be such that the nurse who talks with a physician in an outside agency is in danger of being rapped over the knuckles, metaphorically speaking. There are all kinds of interprofessional tensions, and the nurse may be frightened. It may be obvious that the nurse should refer this patient immediately, but the nurse may be afraid to talk with a social worker.

A consultant should bear this in mind in dealing with nurses or members of other professional groups and try, first of all, to dissipate the stereotype of himself as a social worker. If the consultee finds that the consultant is a human being she will realize that not all social workers are devils. But the consultant must also help the consultee to see the social agency realistically and not as a

dangerous group of people ready to clamp down on her, who will fail to help her patient and insult her in the bargain. These are strong words, but they are the words of stereotypes. When people think in this emotionally toned way, these are the things they think.

There are several things a care-taking agent or a consultant can do in a crisis. He can smooth it over. The crisis in any case will pass. Even if nothing is done, a crisis is a peak of upset, and the people eventually stabilize. The consultant can simply hold their hands and the crisis will pass. Or he can stand on his head, and the crisis will pass. But the next time the consultee has a problem of the same kind he will have exactly the same reaction to it. If the consultees keep coming back with the same kinds of problem, the consultant will know that he has done nothing but weather the crisis with them. What we want to do is give them specific help during the crisis so that some change takes place in their personality structure. When this occurs it will be reflected in their increased effectiveness in dealing with their professional problems.

The consultant must always ask himself: "What are the implications of this appeal for help?" The consultee brings up the problem of this, that, or the other patient or family. It may take two or three cases before the consultant realizes what their common denominator is. Is each case, for example, a situation in which a husband is deserting a wife with several children? Or does the consultee keep bringing you some woman about whom she says: "This woman could really look better if she would take care of herself?" Or is she always bringing you the problem of an old grandmother or grandfather who is being treated badly by the rest of the family? The consultant must look for the implications of all this and ask himself: "Why is this girl getting so upset about this? It must have some special meaning for her. I wonder what it is."

The consultant can find the answer to such questions only by talking with the consultee. As a rule, this requires time. Sometimes one can make a snap diagnosis, but it is better not to. Working with the consultee, reading between the lines, and noticing the type of case she brings up, the consultant begins to feel that the woman is being disturbed by this, that, or the other. He asks himself: "What is the question she's asking me—not verbally, but non-verbally? How can I answer it in a way to relieve her?"

The consultant is asking nonverbally and the consultant must reply nonverbally. He must use the same channel of communication that is used with him. The consultee is talking about the patient and the consultant must reply by talking about the patient.

But if he has diagnosed the situation correctly, he knows exactly what the difficulty is and can respond to it in any terms.

This is an active way of dealing with a crisis and not a mere passive seeing it through. The crisis will pass in either case. But here, the next time the consultee complains it will be about something quite different. She will not complain about that type of thing again.

Involving multiple disciplines

Question

Could the crisis technique be used in the situation of a high school student who contracts a venereal disease? I am thinking of a case in which the principal and public health nurse became very much alarmed. The social work consultant, the parents, and the regional person in charge of the school district were also involved.

Dr. Caplan

I would say that was an excellent situation for this technique. The more excitement, the more upset, the more people involved, the better. You have here a complicated balance and the type of situation in which you can hope to find a common denominator. Sometimes that may involve you in dealing with just one of the people involved, but that will be enough.

You must look for the hottest spot in the situation. If the principal is the most upset, it would probably be best to place your greatest emphasis on him. Your object would be to get the principal to see that this is simply a boy or a girl who has contracted a sexual disease, and not a sexual maniac.

All kinds of problems are involved here, from a task point of view. First, a job has to be done to enable someone to do something about the precipitating problem. The consultant's job is to arrange matters so that other people will deal with the problem as effectively as it is possible for them to do in the light of their previous knowledge and experience. An additional job might be to add to their previous knowledge and experience the specialist's knowledge and experience so that they could do an even better job.

In a situation like this, if you find that someone is tearing his hair out and jumping up and down, the odds are that that person is not task oriented at that particular moment, and that he is being less effective in dealing with the situation than he needs to be. And that is when the consultant should begin.

You might see all these people individually after a group consultation. I do not think there is any rule that can be laid down

there. Because of his status and position a principal cannot allow himself to seem upset in front of a parent or a nurse. Therefore, if you saw that the principal was especially upset, you should see him separately.

You have certain basic principles, but how you actually operate in the field depends on what you find in the field. I have had some very exciting and interesting group consultation contacts, where the whole staff of a school was upset about something. In situations like this all kinds of tensions may come to the surface, and all kinds of forces impinge upon the consultant. If handled in the right way such sessions may be extremely valuable.

Speaking of principals and supervisors, I must point out that there are many cases in which this technique does not work. We are trying to find out what kinds of personalities are most amenable to this technique and also what kinds of institutions and what kinds of social structures. I have a hunch about this, so far as the institution is concerned. If you have an institution which is well integrated, I believe that, other things being equal, you will succeed or fail in your consultation efforts according to the state of your contact with the principal. If the principal has a good relationship with you and understands what you are trying to do and goes along with your efforts, and if he has an integrated institution, you will get good consultation results with the individual teachers or nurses in that institution. On the other hand, if you have an integrated institution and the principal does not go along with you, you will usually fail in your individual consultations. He will arrange matters so that you fail.

Given an institution which is not well integrated, where the principal is unstable and apparently does not have much hold over the people under him, then the principal's attitude matters much less. Sometimes you go into an institution which is rather unstable and which you think, at first sight, is a poor bet from a consultation point of view, with an administrative head who is weak and does not manage to do much, and in which there is a generally unhappy atmosphere, and it is remarkable what good results you can get in consultation whether the administrator is with you or against you.

The institutions which we like least of all are those I call the black-glass-ball type of institution. Here you feel like a fly crawling over the surface of a black glass ball. No one is anxious or upset and everything looks so nice and shiny. But you feel that if you could look through that blackness there would be a lot of terrible things inside. Usually you do not get in. Usually this

type of institution has a specific type of director. I have seen them all over—in Israel, in London, in Massachusetts.

Noncrisis Consultation

I can think of another type of consultation, noncrisis consultation, which borders on what I call mental health education, except that education usually means increasing people's knowledge about general principles. I would describe this type of specialist consultation as increasing the consultee's knowledge about a particular problem or case. Here the consultant is operating as a specialist, and presumably knows more about the situation than the person he is dealing with, and his intention is to increase that second person's knowledge.

In this case the consultee is not emotionally upset, except as anyone is upset when they call for help. The consultant doesn't concentrate on the inter- and intra-personal forces in the situation to any great extent, although naturally we pay some attention to these factors whenever we talk with anyone. In a specialist consultation the consultee does not have the necessary knowledge and experience to deal with the particular problem which is causing difficulty, and the consultant is brought in to help him with his specialized knowledge. The consultant also has the advantage of being an outsider and so possibly able to see more, as a bystander can often see more of a game than the participants. In this type of consultation the principles related to crises do not apply. But the other principles we have discussed, such as those relating to opening up the channels of communication and initiating consultation, are equally applicable here.

Administrative

Question

In our consultation, which is not the crisis type of consultation, we investigate the administrative structure and limits within which the people work, and we try to effect improvements. We pay a great deal of attention to bringing in the administrator and involving him in the consultation process, so that we do not confuse the consultee by consultation which may be inconsistent with the limits under which he works. How is this covered in your technique?

Dr. Caplan

I think you are saying that in your consultation you regard it as part of your function to change the social structure to some

extent. You have certain ideas about what constitutes an effective or efficient way of running an institution and about how administrators and the people under them should get along together. You believe that there are certain lines of communication which should be open and if they are closed you regard it as part of your job to see that they are opened and this, of course, will alter the administrative structure.

I think that is a legitimate type of consultation. You are quite right, it is not a part of the technique I am talking about, although similar results often follow as a consequence of our technique. Our technique is directed to individual personalities in their interrelationships, and we are very careful not to touch directly, or to touch as little as possible, the existing social structure. If we find that channels are closed, we assume that they were closed for a good reason. We feel that if we open up one of those closed channels, all kinds of things might happen which we would not know anything about.

I think that the type of consultation you are talking about is safe only when it is carried out over a long period of time. I assume you spend considerable time getting to know the institution, and that you are there and prepared to pick up any bits that may fall as a result of opening up a channel. You are talking about a method of specialist consultation which involves building up a continuing relationship with the social structure of the institution. In planning for this you must be able to count on continued visits to the institution.

The type of service I am talking about is broader and is planned to cover a very large geographical area, where one does not have the time to do the kind of intensive specialist consultation you are talking about. We deal with problems of a different order; we do not attempt to alter the social structure but simply deal with crises. If you have an area which is big enough, at any one time things will be popping in different parts of the area. You can arrange not to go to a particular place until the pops get to a certain intensity. You go only when you know that the intensity of the crisis has reached a certain peak. And when you have finished in one area you leave it and go to another, where in the meantime the intensity of the crisis has built up.

Our technique is designed for situations where there are a relatively small number of workers and a relatively large number of places to cover. It does not rule out the other technique. A consultant may use different techniques according to the different institutions and emergencies he has to deal with.

It is important that a consultant should not feel himself a mental health consultant and nothing else. He may be a mental health educator one day and a specialist consultant another and so on. He may use various techniques on his rounds. But he should know what he is doing. He should define his function and specify it and make the operations fit into an overall plan. His work should be a directed activity and not a haphazard mixing up of different types of consultation.

I have learned one interesting lesson about interfering with the social structure; namely, if you interfere with a social structure in however minor a way, you must be prepared for a long-term job in that place. Communities, even small communities such as a local health center, take a long time to achieve stable changes in their structure, and one must be prepared for this. One of the big mistakes those of us who have moved from intrapersonal phenomena into the community field make, is to imagine that the rhythm and rate will be the same. Actually communities move much more slowly than individuals and we should be prepared for this.

Another thing that has constantly surprised me is how easily one can fit into the interstices of an existing social structure and, without attempting to alter the structure, deal directly with the personalities and personal difficulties in the situation. Later you are surprised to find, as a secondary effect, that the administration has been altered by the people involved. You did not do it. They did. And they know what to alter better than you do. So, sometimes, the best way to alter the social structure is to leave it alone and deal with the interpersonal phenomena.

There is a certain type of specialist consultation which deals with administration and has its own goals and techniques. But even here one must take into account the human situation. Whatever the task orientation of the people involved, there are always certain human aspects which must be considered. One does not cut out all concern for interpersonal phenomena merely because you are giving consultation in regard to social structure.

There is another type of consultation which has to do primarily with administrators responsible for policy decisions. In preventive psychiatry we are realizing the importance of this type of consultation more and more. Whether it should be carried on by a case-worker or a psychiatrist is not yet clear. We have not yet differentiated our functions in this field sufficiently. But it would be valuable, I think, to have some mental health worker included in the discussions which take place at various administrative levels in regard to policy making.

I mentioned earlier the preventive psychiatric aspects of policy making in relation to a tornado and how a community reacts to a tornado. We have been thinking lately about the possibility of influencing policies in regard to town planning in such a way that the community as it grows will have the physical and geographical facilities necessary for mental health. Policies governing eligibility for admission to a housing project are another example. Housing projects set up by a local authority often have a system of priorities which places a high premium on broken families and other social misfits. In a housing project across the road from the public health center where I work, 40 percent of the families are without a husband, without a father. In such families problems of disciplining the children are difficult. This produces various social symptoms, various uncontrollable delinquencies among children, which quickly spread to the other people in the housing project. The project becomes a breeding ground, a contagious area for social symptoms which very easily turn into psychiatric symptoms. A situation like this should be studied by mental health workers and their findings should be used to form admission policies, which would keep the number of social difficulties below the contagion level.

Another place where preventive psychiatry should be considered is in policies regarding hospital visiting.

In England, even before Bowlby has been able to prove with any degree of scientific accuracy that mother-child separation is in fact a pathogenic factor, there has been a directive from the Ministry of Health to every hospital with a pediatrics department to allow daily visiting. This will revolutionize policy throughout the country and strike an important blow against the pathological effects on personality of mother-child separation.

Another example of this kind of policymaking occurred in my work in Israel. I worked in the Ministry of Health, with people who were responsible for planning how to receive immigrants into the country. When I arrived in 1948, the recent immigrants were being housed in huge camps, in barracks left behind by the English Army. That was all that was available. The people were put into these large barracks, about 30 or 40 to a hut, and left there. There was no space for doing any kind of work. The immigrants stayed in these camps for 6 months or a year, getting more and more apathetic. Those from the concentration camps of Europe began to compare their present situation to the concentration camp. When, later, you tried to move these people out to places where they could work and be on their own, a number of them did not want to go.

So we suggested that, instead of bringing the immigrants into these large camps, we should do what we could to put them in small

camp where there would be work for them to do, and to provide materials so that each family could have its own little hut. We put them, first, into little tents, and then into crude aluminum huts. From a practical point of view they had been better housed in the old barracks, but the effects on the morale of the immigrants was surprising. They came to Israel and were immediately able to start working; we did not get the retrogression into apathy and depression which we had had before.

We are beginning to know something about the larger community factors which influence emotional well-being; and I am confident that the mental health worker can make positive and constructive suggestions in a discussion on policy at this level.

When you are giving consultation of this kind, the administrators turn to you and say, "What shall we do?" We cannot tell them what to do, because we do not know enough about it yet. But we can at least take part in the discussion and make our kind of contributions, that is, we can present a point of view which takes into account the psychological needs of people. And we have developed certain hunches, at least, which are better than the ideas of people who have no knowledge at all of the mechanisms of interpersonal relations at this particular level.

We have been speaking of the level of high administration policy planning. One can get into these problems at various lower levels, such as in curriculum planning in the school system. The people organizing the school system are constantly reorganizing their curriculum. A mental health worker sitting in on such meetings can make valuable contributions by encouraging curriculum policies which promote mental health or prevent emotional ill-health.

I worked, rather unsuccessfully, with one school system in which we quickly spotted one factor that was conducive at least to a weakening of the emotional stability of the children. Apparently at every possible opportunity, these people chopped the classes up into groups in an arbitrary way without any regard to the friendship patterns among the children. At the end of the school year, perhaps 90 children would be divided into "A", "B", and "C". The children are shuffled together and divided again, and each class is now different. The split is usually by chance. As far as the school people are concerned, this is supposed to be a good thing. They feel that children should learn at this young age to mix freely. And with many of the children it does not matter too much. But with some children, this produces special problems. Here the culture of the school and the philosophy of the educators runs counter to the ideas of the mental health people. This is a matter which should

be explored. Some kind of experiment should be set up to find out what happens when you have one policy in effect and then what happens when you have another.

Group consultation

Question

You mentioned earlier, consultation to a group. Do you then consider your group as your consultee? And do these principles and steps apply in a more complicated way to the group than to an individual consultation?

Dr. Caplan

Social scientists often accuse psychiatrists of saying a group has "personality." We must be aware when we are talking about a group that we are talking about a rather complicated unit, but it is a unit. It is more than the sum of the individuals involved.

When I have to train a mental health consultant I like to get someone who has had experience in group psychotherapy of the analytic type, because such a person has had the experience of dealing with the unit, the emotional unit, of the group. If you do not like the word "personality," use something else. You might call it "group atmosphere." There are certain aspects of the culture of the group which can be thought of as being in equilibrium, and certain aspects which can be thought of as being in disequilibrium. In a group consultation, that is what you are dealing with. It becomes practically impossible to deal with the number of two-body relations created by relating yourself to each member of the group.

When you are dealing with a group as a whole, you have to be aware that it is made up of "A", "B", "C", "D" and "E", although "B" or "C" may stand out in the group. Perhaps the group manipulates "B" into a certain role, or perhaps stimulates certain things in him. You have to decide whether you should split the group up, or deal with it as a whole, or do both. This is a matter for individual experience. But it is possible to deal with a group as a unit which has a culture of its own, traditions of its own, a history of its own, certain accepted values, and which may be more or less effective in dealing with these problems, in perceiving them and analyzing them and solving them. As a mental health consultant your goal is to make this group as effective as possible, insofar as you can help them to remove emotional blocks which are upsetting them in dealing with their problem.

If you deal with the group as whole, this in itself has a remarkable and potent effect on every individual in the group. A change

in the group atmosphere changes the feelings of every individual, and this follows the lines we have been discussing. At every moment in the here-and-now situation every person in the group is linked by these invisible but potent bonds to the other individuals in the group. There is a constant interchange between the individual and the group, moral or spiritual or whatever you want to call it.

Consultation to the supervisor

The crisis type of consultation only works for people in crisis. The supervisor may be in crisis. That may be why she has chosen to ask you about a particular nurse's problem. If she is personally upset about it, then she becomes your consultee. A satisfactory consultation with a supervisor or director of an institution may change the whole balance of forces within the institution. On the other hand, if the problem is a nurse who is in crisis, it cannot be handled through the supervisor.

In the case of specialist consultation, however, work with the supervisor is very appropriate. The supervisor probably remains at the institution longer than any of the nurses. She can spread the knowledge to the other nurses. But in crisis consultation, one must deal with the person who is in crisis, although this does not mean that other methods of consultation are not also appropriate.

When working in a school system we consult with the principal in practically every case, in addition to consulting with the teacher. This presents a difficult technical problem of how to make sure that certain lines of communication remain closed. The consultant must not report to the principal information which he has received in confidence from the teacher. Many principals want to know what happens in the interview with the teacher, and the consultant must not tell them.

Consultation in a three-body situation

The consultant is sometimes expected to give consultation when a nurse and her supervisor are both present. This can be handled, although it is one of the most difficult types of group situations, a three-body situation. It is handled along the lines we have discussed. The consultant must realize that if both are upset there is a common denominator somewhere. Somewhere or another there is a point where everything involved is vibrating on the same wavelength, and it is the consultant's job to find it.

However, if the supervisor is present and only the nurse is upset, you will be offering crisis consultation for the nurse and

specialist consultation for the supervisor. This may not be a tenable position. The nurse may be upset because of the presence of the supervisor. In that case, the consultant cannot accept the situation as it stands.

The question then is, how you can break through a situation like this. In attempting to do this are you attacking part of the social structure? Usually in public health programs there is a fairly rigid social structure which has a reason for being and which you cannot attack with impunity. This is a matter which has to be decided individually for each case. It may be that a particular structure is so rigid and that so many other important forces would be upset if it were broken through, that this type of technique cannot be applied.

Arranging matters so that you can do your work may require indirect action. You may begin by doing as you are asked and little by little find out what the situation is. When you feel the time is ripe you may suggest that it would be advantageous for you to have a longer talk with the nurse, that you do not want to take the supervisor's time, and that you will talk with her afterwards for 5 or 10 minutes—or something like that. Or you might approach the matter directly and say: "If I'm going to be of maximum use here, I will have to deal with certain situations which are fairly private. I am not interested in the private relationships of any one person, but if I am to get a certain type of knowledge about the situation, it will have to be done through individual conferences."

It is understandable that a nurse should feel inhibited in talking before her supervisor about something with which she has difficulty. This type of explanation is easily accepted by the people involved, as long as it does not cut across too important defensive lines. The defensive lines may be partly social structure lines and partly personality lines. There are some supervisors who cannot bear to have anything happen without their presence. In this case, the consultant must be sure to discuss the patient with the supervisor afterwards, but he does not have to discuss what the nurse said.

The important thing, from the community organizational point of view, is to steer a way through the lines of forces and to avoid as much as possible cutting across any one of them. And if something must be cut, the consultant should know beforehand what is going to happen when he cuts. He must be aware of all those little things which seem insignificant to an outsider but which are tremendously important to the people involved. These often represent the end result of a long tradition of motivations and tensions and

conflicts which have eventually crystallized into something that is comfortable. However peculiar this social structure may appear, it is in an equilibrium which has been produced by a long and complicated process. One cannot touch anything in equilibrium without expecting the whole system to shift around.

Multidiscipline team consultation

In a multidiscipline team approach it is very important that the team know beforehand what they are going to do, which wave length they are going to operate on. It would be hazardous indeed to attempt this type of consultation without a unified approach and a rather free interchange in communication beforehand and at the time between the people involved. Stanton²³ in his fascinatingly documented book has shown the very close connection between tensions among the staff and tensions among the patients, or actual symptoms in individual cases. This applies in mental hospitals and everywhere else too. Where a staff deals with clients or patients or with consultees, any unresolved tensions among the staff members—intrastaff blocks of communication—immediately work themselves out and show themselves in a reciprocal kind of way among the consultees and the clients. The reverse is also true. If cohesion exists in the staff, if they are all operating in the same wavelength, this too is carried over to the patients or consultees.

Question

What about a telephone contact, where someone calls more or less just for information? Many of those telephone contacts are pretty loaded emotionally.

Dr. Caplan

Telephone contacts are usually very loaded in this field. The important thing about them is to try to get the call followed up by a more personal contact. That should be the goal of the person on the telephone.

One of the most important members of the staff of any agency is the telephone girl, because she is the channel of communication to the outside world. It is remarkable what an effective telephonist can do for an agency. But it is equally remarkable what a poor telephonist can do for an agency. The hall porter is also very important. In a public health agency, or in any agency dealing with the kind of things we have been talking about, the in-service

²³ Alfred H. Stanton and Morris S. Schwartz: *The Mental Hospital: A study of institutional treatment in psychiatric illness and treatment*. New York: Basic Books, 1954. 492 pp.

training of the staff should certainly concentrate on the employees who are the link between the agency and the public. Very often people who appeal to an agency come and get the brushoff from some rather busy and snappy girl on the phone. You do not know what happens to these people afterwards—sometimes rather unfortunate things.

Structure of Consultation Services

Member of same staff

Whether a consultant can be a member of the staff of the consultee institution is a knotty problem. At one time we believed the answer was No. We felt that no one who was a member of the institution could maintain the objective point of view and the lack of involvement necessary for consultation. Nor could he, looking at the institution from the inside, take the overview needed if he is to assess how the forces are operating. Such an individual would have a different understanding of the forces, and that understanding would be colored by his own emotional involvement in the situation. He would also be exposed, as a member of staff of the institution, to the various pressures of that particular social system. He might not be able to resist the manipulation or the pulling or pushing of roles which, as a consultant, he would have to resist.

For instance, what would happen if this consultant's immediate administrative superior wanted to use him for some purpose of his own, which might be perfectly legitimate from the point of view of the former's role as administrator but not from the point of view of the latter's function as the consultant? Suppose the immediate superior should say: "I'm not too sure how Miss X does her work. Is she really competent? Is she a crazy person?" He thinks: "Maybe this psychologist can tell me. I could take advantage of some of these techniques of this mindreader." Of course, this is a slight exaggeration. The administrator would want the consultant to give a report on the mental health status of Miss X and plan how to deal with her—how to get rid of her, or how to do this, that, or the other.

Would not this be outside the province of the consultant, and if so, could he resist such pressures? And what would happen if he gave in? The news would be out almost before he got out of the room, and the next time he saw Miss X, or Miss Y, or Miss Z, their attitude would be: "This is someone you have to be very careful about. You have to guard what you say." In other words, he would become closely linked to the administrative group.

On the other hand, if the head of the department had more understanding he would not ask this of the consultant, or if he did, he would feel that the consultant was entitled to say, "This is not within my province."

The question then is, whether the consultant is strong enough to define his role so that he is flexible but has limits beyond which he does not go. A consultant is beset with tremendous forces and, unless he is an individual of strong personality, it may be hard for him to withstand some of the pressures. For example, a social worker on the staff of an agency who is expected to act as consultant will have to take into account all the forces inside that agency. How well she can do this will depend upon the degree of self-awareness of the people in the agency.

During the time I have worked with the Family Health Clinic in Boston there has been a very definite increase in self-awareness among the nonsocial workers and nonpsychiatric members of the team. We now speak explicitly, and freely, about personal involvements. For example, an obstetrician who had just seen a young hysterical patient said: "That girl's hot stuff. I get quite stimulated by a nice looking hysteric." This was said at a meeting of social work students and some of the girls were upset by it. The obstetrician was speaking openly about something which a few years before he would have run from, namely, that a doctor may be sexually stimulated by a patient. Once that would have been a terrible thing to admit. Now he is able to ask the group for help and the group is able to discuss the fact that a hysterical girl sexualizes a situation. This is an important diagnostic pointer; the obstetrician's feelings may be one of the first indications we have of the girl's condition.

It took a long time before the members of our team were able to make things like this explicit. I, the psychiatrist, never made them explicit. I waited until other people brought them up. Until then we dealt with the situation as best we could, knowing that there were certain personal involvements taking place that one did not talk about.

This is a different situation from the usual one in consultation, where the consultant goes into an institution and out again, and does not have this prolonged relationship. The type of consultation I have been discussing presupposes a situation where the consultant goes in once a week or once a month and then does not go in again. You do not have the developing relationship that you would have if everyone were working inside the same building. In Boston we have been working inside the Whittier Street Health Center, and

we have discovered that we do sometimes use the mental health consultation techniques, but not very often. We use this technique with possibly 3 out of 10 nurses. With the others we use different techniques. With the group as a whole we are developing a valuable relationship. We are careful not to move too quickly and to be sure when we change our procedures that it is done with the sanction of everybody concerned.

For example, we said at one time that we would not take any cases away from the nurses. This was our maxim, our platform. We were studying certain families, and we said that we would always study with the nurse. Everybody agreed to this. We also said that any change we made in our plans, would be discussed with the nurses first, and would be a joint decision.

We were taking as many cases as we could handle, but not all that came in. A little later the amount of time we had for interviewing was suddenly doubled because, instead of using two interviewers—one interviewing and one observing—as we had previously done, we decided to combine both functions in one person. So, from one day to the next, we had double the number of interviewers available. We had a steering committee in which I met with the head nurses and physicians of the building. I informed this committee that now that we had double the amount of time we would take all the cases that came. They agreed.

The next week there was a little incident. We wanted to go out on a case that had just come in, and the supervisor said: "We want to use this for a student." We had also told them, "When you have a student on a case, we don't want to go in," so we said: "We'll wait. You take the student in and we will go in after a couple of days." The next day we asked about this case and were told: "We decided to put the student on another case. We decided this was your case."

That immediately showed us that something was wrong. Their saying, "This is your case," meant, "It is your case—not ours. If it's our case we will take the student in. If it's yours we will not." Obviously, they no longer felt that we had joint cases. What had gone wrong? The fact is, we had not worked the change of policy out with them; we had not obtained, in any honest kind of way, a general agreement that we should take all the cases that came along. Moreover, as we now realized, we had never worked out with them, but had merely told them, "When you have a student, you take the student in, and the next day we will go in with the nurse."

This was a logical procedure but we had not worked it out with the others. There had been no consensus on this. Now we were

getting it back. They were saying: "You say you will not take our cases away from us, but you do. However, we like you and if you want a case, take it." At this point we realized that we had stepped on someone's toes; we had said one thing and done another.

This illustrates the importance of being sensitively aware of what is going on. People can become aware if they are working in the same building. We were acting as mental health consultants to the nurses in whose building we worked, but we were not employed by the city health department. We are employed by the Harvard School of Public Health. We had no direct administrative connection with the nurses except that the city department of health permitted us to carry on this program.

I am not sure what would happen if I were a physician in the city health department and were trying to build up this relationship with the nurses. As it is, I have the advantage of being a physician, but not a physician who has an institutionalized role in connection with the nurses. If I did have this role I doubt whether the nurse would be able to talk with me as freely as she does now.

Member of supporting group

Some of us feel that a consultant should not operate as an isolated individual in any field; that is, that a consultant should always have behind him a supporting group which is uninfluenced by the field. The consultant should act, as it were, as an emissary of this group, a technical and emotional emissary. With this group behind him, he can allow himself to be manipulated, because he does not rely upon his own strength. This is an important thing, and a possible solution of the problem we are discussing, provided it can be worked out.

We have tried to work out something like this in Massachusetts where in the State division of mental hygiene there are about 15 "mental health consultants," some of whom have specific jobs and job descriptions. They are not called mental health consultants. They are called something else which fits into the administrative framework and gives them the right rate of salary. These people go to different parts of the State and consult with various school systems. Each week they come back to a seminar at Whittier Street. The seminar acts as the core group and is outside the framework of the State division of mental hygiene.

It is not our function to deal with anything political or administrative, and every now and again some of the consultants test me

out on this. They tell me that their "boss" says this or that and ask my opinion. It is then my job to make it clear to them that this group does not enter into administrative wrangles. Having the support of this group makes these people much more comfortable and stable as they go out into the field.

Whether this sort of thing is possible under all circumstances is the question. Possibly some way could be found of having a consultant within the consultee institution, so that he is in the institution but not of it, so that without being made a pariah, he has certain artificial barriers set up between himself and his colleagues. These are some of the exciting unsolved problems.

Question

To what extent can this crisis technique be used by the isolated worker who does not have the protective structures of a group for moral support?

Dr. Caplan

There are some levels at which a lone worker can carry on adequately. It would not put any great personal strain on a lone worker in Alaska, for instance, to deal with the crisis situations of actual people in the field. That is, if she comes across a family in crisis, she should be able to handle it.

The worker is more likely to have difficulty at the other level of consultation practice, where she may find herself involved in cross currents, as in her central or peripheral office where she gets caught up in tangled relationships which impinge upon her more closely. The further the problem is from her personally, the more able she is to feel professionally distant from the people involved, the easier it is. The things we have been talking about, these fundamental aspects of what you might call the ecological theory of mental health, can be taken and used in any combination by a worker in any situation which is comfortable to her and compatible with her personality and technical knowledge.

You may say: "If crisis consultation is an effective tool, it may be effective for evil, too." That is, if you interfere in a crisis and do the wrong thing, you may push in the wrong direction. This is a chance we have to take. We are dealing here with a potent technique, and we have no assurance that it will not be misapplied. If the worker is not sure about what ought to be done, the best thing would be to sit still and see which way the person is moving spontaneously. There will always be a next time. The beauty of it is, that if you push in the wrong direction, you do not go very far; if you push in the right direction, you really get somewhere.

Clarity of Role

With nursing consultant

Question

Is it sometimes better to do our consulting through the nursing consultant rather than directly?

Dr. Caplan

A casework consultant and a nursing consultant fulfill different functions. The casework consultant is trained to deal with pre-conscious if not unconscious processes and the nursing consultants are not. Except for certain very specialized individuals, I do not think nursing consultants could use this technique of mental health crisis consultation. They could do specialist consultation very well, probably better than a casework consultant when it concerns the actual details of a nursing job, because they are nurses. A caseworker or a psychiatrist should be very, very careful not to impose psychiatric or casework techniques upon nurses. We sometimes lose sight of the fact that our way of thinking about something is part of our special background. Even when merely talking with a nurse about what one sees in a situation, one must be careful not to try to turn her into a caseworker or a psychiatrist.

From one point of view, the nursing consultant has the easier job. She can be free and uninhibited. She is a good nurse and if she can get the other nurses to identify themselves with her, that is fine. She will be enlarging the other nurse's vision and helping her to be a better nurse. A casework consultant, on the other hand, by virtue of her professional background, may be expected to have more profound knowledge than a nurse about social structure and cultural matters and also about the inter- and intra-personal factors in a situation, especially the unconscious or preconscious ones. In other words, the casework consultant operates in some areas which are separate from those in which the nurse consultant operates.

A great deal depends on the personalities of the two people involved. It is a question of working out, by mutual give-and-take, a teamwork approach. A teamwork approach is a very difficult thing to work out, especially between professions which have a history of mutual tensions. If, for example, you are trying to build up a partnership between a caseworker and a nurse, you will have special difficulties to work through, which are the stereotypes each profession has of the other. After this, you may have to work through the individual, personal stereotype which each one has of the other.

After these things have been accomplished, you may take up the question of who does what. This can be a battleground, but it can also be very profitable. It is like working through resistances in psychotherapy. I do not mean that the caseworker works through the resistances of the nurse. In our work it is not a question of the mental health workers attending to the public health workers. We use the same scrutiny on ourselves that we use in regard to what the nurses are doing. We also are part of the field of forces. In the public health field, the nurses have an approach which is as dignified and competent as any we might have in our own field. We must work together as equals, which is no easy matter. It is easy to preach to others, but not so easy to practice ourselves.

With consultee

Question

As social workers we have to explain to a nurse, in accordance with her limitations, what she can do with the amount of knowledge we are able to give her. That is sometimes difficult, because there are so many different kinds of public health nurses, and some of them are not fully trained. You have to know exactly what the one you are working with can do and what you can give her.

Dr. Caplan

That is absolutely right. When we work with another profession, we must learn as much as possible about that other profession, and learn humbly, I would add. But the mental health consultation technique cuts deeper than this. It is aimed at the human rather than the professional aspects of the work of the nurse or the teacher.

I know nothing about education, for example, or very little. If a teacher asks me what to do, I say I do not know. This would be more difficult for those of our consultants who have been educators. If the consultant has been an educator, it is difficult for her not to slip into the role of group expert and give advice on what the teacher should do, because she knows what she would do if she were that teacher. Similarly, as mental health consultants, we do not deal with the nurse's professional nursing techniques. We leave them alone. The nurse consultant can tell the nurse anything she needs to know in regard to nursing. We deal with the human aspects of the situation, which we want to make as free from tension as possible.

Question

When a public health nurse brings up a family problem, can the mental health consultant see either the wife or the husband and the nurse see the other, and then pool their information?

Dr. Caplan

My first impression is that this would be a risky thing to do there, since the mental health consultant would be infringing upon the territory of the nurse. Her function is to help the nurse deal with public health nursing problems. If the nurse has a family to deal with and is seeing the wife but avoiding the husband for some reason, there is something wrong. She is not acting as effectively as she might, perhaps because of lack of training or experience or understanding. If she were identifying herself with the wife and feeling angry with the husband, this might be a factor. The consultant should ask herself: "Is it because of some emotional block in herself that this is happening, or does she just not have the techniques available to handle this?" If it is the former, the consultant should use mental health consultation techniques to free her from it. If it is the latter, she should use specialist consultant techniques, discussing the situation with the nurse, enlarging her vision of what is taking place, helping her to put a little distance between herself and the wife and to see that the family also includes the husband. I would be very wary of taking over anything which I felt the nurse herself should have been doing.

I would not say that one should never see the nurse's patient. This might be a very effective technique, if the nurse is having difficulty with the family. It might be very effective to go out and see the family with the nurse. But you do not take over the case. You see the family in order to throw more light on it, and you use the situation to dissipate whatever stereotypes the nurse may have.

Question

I was thinking of a situation where the wife is complaining to the public health nurse about the husband. If the nurse had to interview the husband that might make the wife suspicious and create even more disturbance.

Dr. Caplan

I feel that you are, erroneously, putting forward a point of view derived from the practice and thinking of child guidance clinics, where it is taken for granted that the same worker should rarely see both the husband and the wife. In these clinics it is commonly held that in a conflict between parent and child or hus-

band and wife, the same worker should not see both parties for fear of making them suspicious. Why shouldn't they be suspicious? Their suspicion gives you an opportunity to bring to the surface crucial aspects of the situation and to deal with them. If the wife becomes suspicious when the nurse sees the husband, that is excellent. Let her be suspicious. Let her raise the question and put it on the table. Let them see the wife does not trust her husband, and the husband does not trust his wife. Let them talk about these things.

This is a much more effective way of dealing with such problems than the traditional way of dividing the problem into compartments and then talking about teamwork between workers who rarely see each other except running into or out of the building. When you have two compartments such as this, the clinic is perpetuating the lack of communication between the husband and wife.

I do not deny that when the same worker interviews both you are likely to get into difficulties. But you must differentiate the difficulties which you can use for the advantage of your work from those which prevent you from working. Possibly the greatest advance in psychotherapy in our generation has been the realization that resistance is not merely an obstacle. It is the crucial point. Dealing with resistance is the crucial point in psychotherapy, the point where you really move your patient forward.

One of the best ways of dealing with marital disharmony is to bring these kinds of suspicions to the surface. For some years now, I have made a practice of treating husband and wife together, of seeing them both at the same time. This usually produces quite potent material.

Consultation vs. inspection

Question

A health officer consultant from the State health department has been called in to discuss trouble in a county health department by the county administrators, but the county health officer has not been informed. Should the consultant insist that the health officer be informed of this request?

Dr. Caplan

This depends on the accepted definition of local functions. It is a ticklish situation that I would be sorry to find myself in. However, if you are compelled to go over someone's head, you might make it one of your first goals to find out why this person was not

informed, or could not be informed. Possibly your first goals would be to work through this as a symptom of the situation.

Where there are channels of communication which should be open but are actually closed, you must use a special type of consultation technique. What you do depends on what you find in the actual situation before you. Perhaps eventually we will develop certain basic principles for that kind of situation, but at present we cannot lay down any hard-and-fast rules, except to beware of being used by one set of forces or one party against another.

Of course, one's allegiance may put one in one camp. If you are a member of the central staff of the State health department, which officially or unofficially inspects the activities of the county health departments, this may be your job. You may not like to use the word "inspection," but that may be what it amounts to. You may go in because there is trouble and you want to know something about it. In that case your function is primarily that of an employee of the State health department, and only secondarily that of a consultant.

The important thing is to know which cap you are wearing, and not to use a mental health consultation technique when you are actually an emissary of the State health department coming to deal with some administrative trouble. If you do try to use these techniques, you will be operating on the wrong foot.

Promoting use of services

Question

You say that consultation should always be on the request of the consultee. Well, there are situations, particularly in a health department's work with communicable diseases, where the nurse might feel comfortable enough with the situation, but the control officer or the public health officer is insisting that the patient be isolated immediately and that the consultant help the nurse, whether she wants it or not, to get the individual in. Is that still consultation?

Dr. Caplan

No, I do not regard that as consultation; that is administrative pressure. The appropriate channel for applying that administrative pressure is the supervisory network. It is the job of the supervisor of nurses to bring pressure on nurses to do their duty. The consultant should be outside that line. If he once gets mixed up in that line, he will be unable to function effectively. The nurse

knows when he is outside that line. And if he is part of it, he will be unable to persuade her that he is not.

I suppose you all know about the detached social workers now working with gangs of delinquents in many cities, at least on the east coast. Here, where there are many gangs of juvenile delinquents, a new technique is being developed. A caseworker goes out into the neighborhood where the gang operates, makes contact with the gang and forms a sort of street-corner club. Some of these social workers, because of their feelings of guilt, call their technique aggressive casework. They feel that they should sit in offices and have people come to them. Other people call it reaching out.

These workers go into the community and they use techniques similar to those which we call "creating proximity." For example, one worker wanted to make contact with a group of delinquent girls who were operating out of an alley she had discovered. The gang gathered there at all times of the day. The worker stood across the road and stared at them. This went on for a few days. These children got more and more uncomfortable.

Eventually they sent one of their boy friends across the road to contact her. She was smoking a cigarette and the boy came over and asked her for one. She handed him the package and said, "You can take the package if you want." He said: "We're wondering who you are. You're either a policewoman or a social worker." She said, "You guessed right. I'm a social worker," and added: "I belong to the Association of Neighborhood Clubs."

The boy left it at that and reported back to the girls. A little later another boy came over and made contact, and then the group asked her over to them. The gang had now issued an invitation, but only an invitation to be looked at from close quarters.

They then proceeded to test her out. Was she a friendly person? Was she really a policewoman? Could they get anything out of her? What could they milk her for? This testing-out period went on for weeks until she established herself in their esteem. After that, they began turning to her with their various problems.

This is a new technique for social workers, especially social workers who have been sitting in offices. One might say she was forcing herself upon them, forcing herself into their area. But she did not force them to take her on. People who work in venereal disease clinics use techniques of a similar nature in their work. They do not just wait for people to say, "I need help. Please give me help."

In Boston the local health centers do not resemble health centers in other places very much, except in external appearance.

There is no regional or local health officer. There is a physician in the building, but he is only in charge of the janitor, that is, the cleaning of the building, and one of the well-baby clinics. The nurses in the clinic are not answerable to him at all. The dentists are not answerable to him, nor the sanitarians. The sanitarians are responsible to the sanitarian in the head office; and so on. This is an old Boston custom.

When we opened our clinic at the health center, I worked for a year before the rest of the team assembled. During that year I went up all these different channels and got to know all these people. I would say: "Look here. Someone suggested we have a mental health program here. What are your ideas? I don't know very much about what goes on here. If you feel there isn't any need for such a program, I'll go away." I was being honest about this. I did not have preconceived ideas of what I wanted to do which I was trying to foist on them.

We worked for about a year at this level. Then on the day the team assembled, I took them around and introduced them to every person in the building, and also took them to the central office. I did it all as rapidly as possible. I had to do this because as soon as any one of them set foot in that building everyone throughout the whole Boston department would know something was happening. It was important that all the people involved should see them and talk with them, see what nice people they were. They already knew me. At least they knew I did not have horns.

In a case like this you should contact everyone, if possible. That is a large order, but if you use ingenuity you can sometimes find ways of doing it. For instance, if you appear at meetings it gives everyone a chance to say, "Who's that person over there?" and as long as you have fed the information in through the key people it will filter down. That is what you are aiming at even though you can not always achieve it.

Problems in Consultation

Consultant-consultee relationships

Question

What about the consultee who does not have good working relationships with the supervisor, but is going to continue working there just the same, so he plays the consultant against the supervisor?

Dr. Caplan

This happens very often and is no easier to deal with here than in casework. The important thing is to recognize what is happening and not be manipulated into an unwelcome role.

The consultee may want to criticize her supervisor, but the consultant does not have to allow this. There is some direction in the interview. This should have been implicit in all that has been said. The consultant does not allow the interview to ramble all over the place in any undirected way. He allows it to roam, paying attention to the implications of what is going on. If a consultant listens to a nurse criticizing her supervisor, the implication is that he goes along with her on this. He should make it clear his function is to deal with her problem with the patient.

Question

You have said that the consultant must wait to be asked for consultation, but suppose that during a consultation, or during an observation such as a lunchtime discussion, the consultant learns that a nurse is having some emotional difficulties that have not been brought to his attention by the supervisor. Should the consultant bring this matter up with the supervising nurse?

Dr. Caplan

It would be better to deal with this problem through the medium of the lunchtime discussion. Some of the best consultations take place in the lunchtime atmosphere. In fact, that is one of the situations where the barrier is lowest, where a person may be willing to talk about something important under the guise of its being just a lunchtime conversation. The question then is whether you want to maintain the contact and how to deal with the supervisor.

Question

How about the nurse's possible feelings of guilt over having discussed this problem with the consultant without having gone through the supervisory channel?

Dr. Caplan

This leads us back to a previous question regarding the hierarchical structure. Again, I would say, it depends on the local situation. If you feel that the nurses are bypassing their supervisor, you are in a difficult situation. You have to decide how far you are willing to go along with this. You can never allow a nurse to talk against her supervisor to you, but you may allow a person lower down in the administrative chain to ask for consultation, bypassing the person higher up. If you feel this is something you

want to deal with, you might take it up with the supervisor and see how she feels about this kind of thing happening. If the structure is big enough, you might not even take it up with her. If the supervisor has 50 nurses and one of them happens to talk with you, you might mention that you were talking with such and such a person at lunch, without mentioning the content of the discussion. Just let the supervisor know you have talked with the nurse.

Question

After we learn that consultation works best if it has administrative backing, we become so mindful of this that we organize ourselves into a situation where no matter who requests the consultation or who needs it in the health department, the health officer has to verbalize or write the request.

Dr. Caplan

In doing this you create a certain amount of delay, which may not be a bad thing. That is, if you delay, you are more likely to get just the top layer of your crisis situations. And you are also protecting procedures for administrative clearance. It is not necessary to remind people in the public health field, but people in the clinical field may have to be told that administrative clearance is one of the very important things in the social structure of the public health department. It is usually set up under some legal framework. There is a chain of responsibility, which in the last analysis is a legal responsibility. It is not just that people are small-minded and afraid that someone will do something behind their backs. There are good, logical reasons for it, and you do not go against this framework if you want to go on working in the public health field.

The important thing, from an administrative point of view, is to work things out so that there is some flexibility, so that individuals can operate fairly spontaneously within the framework. For example, it would be difficult to give mental health consultation if such consultation were bound by a detailed written request from a health officer. But one might arrange matters with the health officer so that the consultant makes a visit at certain intervals, and that at these times there would be considerable flexibility about which members of the staff should see him. Any members who wanted to see him should be given clearance that day, since if they wait 3 weeks the crisis may be over.

Here again it is a matter of maneuvering yourself to fit into the interstices of the administrative framework. You must beware of cutting across the administrative framework. And you must

also beware of being jockeyed into a position where the administrative framework makes it impossible for you to operate effectively.

Question

Suppose you have been asked to consult about a particular problem and have not been skillful and in some way have hurt someone's feelings. Or suppose you have been unskilled and awkward, and the health officer or the social worker or the nurse openly indicates that no more consultation is desired. Is there anything one can do to improve this situation?

Dr. Caplan

I think there is. The best thing is to maintain contact and try to ventilate the feelings involved in the situation. The worst thing possible would be to do what you might feel you wanted to do, get out and never go back again.

Think of our public health nurse and what she has to put up with. She meets this every single day. She has doors slammed in her face. Her natural impulse is never to go there again. It is important for us to realize that we can bear this and that it is one of the things we have to bear. We should always go back and do our best to clarify the situation. We should give the other person a chance to shout at us. Some of the best work is done after a person has let off steam and attacked you, and found that you remained objective and professional even in this situation. You must not take such things personally. If you make an error in technique, it is not through evil intentions. Perhaps you have not sufficient experience in using the technique, or perhaps the technique is not as effective in these situations as it should be.

This reminds me of something that happened to one of our best mental health consultants while she was working in a school. The principal told her to go to a certain kindergarten class because there was a child there that he thought she should consult about. But when she got there, the kindergarten teacher said: "I didn't send for you. What do you consultants do anyway? You just get money for nothing." She kept this up for about an hour. The consultant just dug in her heels and maintained her role. She said, "The principal did tell me to come here. Is there in fact anything the matter with the child? As a matter of fact, I'm not forcing myself on you at all. This is part of my job. You may not like it, but it's my job." She continued to talk to her in a nice, calm way. The teacher calmed down reasonably soon and it turned out to be a very successful contact.

What had happened here was that the kindergarten teacher felt she was being persecuted by the principal and that the con-

sultant was the principal's strong envoy come to beat her over the head. As soon as the worker was able to dissipate this stereotype, the two women began to understand each other. Here was a teacher, obviously very upset, caught in some situation which was really pressing on her. She was letting fly in this way because of her own feeling of insecurity. The consultant was able to break through her own stereotype of the teacher as well as the stereotype the teacher had of her. This led into consultation. After all, why shouldn't the teacher want to talk with the consultant? What harm was there in talking with her about the pupil, if the principal thought the pupil was disturbed? Surely that was sufficient reason for discussing it.

To return to the case you brought up. Suppose you do make some clumsy formulation or do something which steps on someone's toes. That is no reason for someone to blow you into the next world. If somebody wants to do this, that in itself makes an excellent situation for dealing with the problem through the mental health consultation method.

Question

What about the technique of simply being honest, with yourself and the other people, and saying: "This wasn't very satisfactory, was it? I can see this didn't work very well."

Dr. Caplan

Again I would say it depends on the persons involved. For instance, the other day I said to an analytic patient, "I'm sorry I said that 6 months ago. It was a mistake," and the girl was delighted. Imagine, an analyst saying he has made a mistake! We are not omnipotent. We are not gods. It is a good idea to state this explicitly. We can make mistakes.

On the other hand, we must not impose upon our patients and clients by beating ourselves on the chest and expecting them to forgive us for the mistakes we have made. That is a burden we should not put on them. If you forget this, you may be using your consultee to dissipate your own feelings of guilt. So you have to steer between those two possible errors.

Resistance

There will always be resistances in the consultation relationship, but they are not quite the same as the resistances one deals with in psychotherapy. Psychotherapy is set up with a specific contract which both parties agree to. There is a framework. There are a certain number of sessions a week, and so on. All this has a spe-

cific purpose. The psychotherapist uses the framework to handle irrational deviations from this context, and you get a struggle, as it were.

Psychotherapy consists largely in a struggle on the part of the psychotherapist, allied with the sensible, reasonable part of the ego of the patient, against the irrational side of the patient. Without this partnership with the sensible, rational part of the patient, the psychotherapist could not handle the resistance which ensues. This is different from the Rankian idea of a struggle between caseworker and patient. The psychotherapist who starts struggling with his patient comes to grief. He is putting his weight on the side of the observing side of the patient. The object of psychotherapy is to create what is called a psychotherapeutic split. You divide the conscious, rational side from the other side and enable the person to look at his irrational side which is compelling him to do all sorts of irrational things.

This process, if not impossible, is extremely difficult and hazardous in consultation. Usually all kinds of other people are involved, who cannot be controlled. In consultation we are dealing with a public phenomenon. Although the consultation interview may sometimes be a one-to-one session in a room, it very often is not. Very often it occurs in a public place, in a dining room, or, in our high school system, in the men's or the women's rest room. In high schools consultation contact is often difficult to achieve. But when the teachers see the consultant in the men's rest room or the women's rest room, they feel, "These consultants are human beings, since they do the same things we do. They're not dangerous." At this stage, the teachers will come up and say: "By the way, I suppose this has nothing to do with anything. It's just a little insignificant problem." Then they present their most pressing problem, in a situation where the barrier is lowered.

Even when the consultation does take place in a room without other people present, the consultant must realize that it is a public thing, that as soon as he goes out of that institution, or even while he's still in it, other people are talking about what is going on. And as soon as he goes, the person he has been consulting with will also go around and talk about it.

Initiation of services

Question

Suppose you were asked to help establish a new service, and the health officer said he wanted a consultation service, pure and simple, and there had been nothing of the sort before. Do you

think you would have much chance of success if there had not been some kind of service offered previously so that the community could know what to request?

Dr. Caplan

I believe you are asking whether it is necessary that the community should have had therapeutic facilities in the past, or whether one can just go in cold, so to speak, and give consultation? I am not sure that I know the answer.

We have had some experience of going into a community which has had no mental health or psychiatric facilities and providing mental health consultation. By and large it has seemed to work out. But there are many problems here. You get a demand for individual services and a gradually increasing frustration, because the presence of the consultant stimulates the community to wish for therapeutic facilities as well as preventive ones. This, in turn, weakens their previous methods of dealing with psychiatric cases.

Let us not lose sight of the fact that communities which have no psychiatric facilities within a reasonable distance nevertheless do have psychiatric cases. The community has its own ways of handling these, or of adapting to them and helping them. It may be that the fellow who keeps the corner drug store, or the fellow who keeps the local saloon, or the clergyman, is acting in the capacity of therapist. The whole community, or the culture, also arranges itself in such a way that there is an acceptance of deviation up to a certain point. Communities vary greatly in the amount of deviation they are able to accept. As soon as a psychiatric worker appears on the scene, this equilibrium is upset and the old ways are thrown over, sometimes before there are new ways to replace them.

I believe that it is easier to set up a consultation service in a community that has had no service facilities at all in the past than it would be in a community that has had service facilities which have then been discontinued for one reason or another. In the second case, you come into a field which is littered with tangled relationships and the remnants of old conflicts and tensions, not to mention, of course, whatever it was that caused the discontinuance of the previous service facilities.

Experience has shown that, in a situation such as you mention, one can build up an effective program, provided that sufficient attention is given to what you might call the community organization aspects of the problem. You must remember that when a mental health consultant comes into a community his very presence there is going to set all kinds of forces in motion, and all kinds of

things which were previously dormant are going to come to a head. If you do not pay enough attention to these, you will have a difficult time.

Technique of creating proximity

Question

How would you go about initiating a specific service, such as a service to alcoholics, where public education is very much needed, if you were not invited to do so? You have said that one should be invited. Do you mean that one should go on giving treatment, hoping to prove himself so that people will come to him? Or do you feel that one might reach out and, as it were, inject these services of public education into the community and the various agencies?

Dr. Caplan

The answer falls between these extremes. In the first place, there are ways of getting invitations. You should not go until you have been invited, but there are techniques for making it easier for people to invite you. We have been studying one of these in the smaller context of a public health unit, an operating unit where there are about 10 city nurses and 10 visiting nurses. Here we are investigating the way in which a group of mental health workers builds up a partnership with a group of public health workers at the grass-roots level.

One of the things we want to learn is how to lower the threshold, or reduce the barrier, which exists rather naturally between, say, the public health nurses and the psychiatric workers. We meet the same problem in high schools during mental health consultation. In the elementary schools each teacher has a class of about 30 pupils and is intimately associated with each of her pupils and feels responsible for taking care of them. In the high schools, on the other hand, the teachers operate as specialists and one teacher may have contact during the course of a week with 200 children. Each child has several teachers and the teachers are not very close to the pupils. As a result, the whole process of consultation is quite different.

We have discovered a technique which we call "creating proximity." It is based on the fact that, if you are around and if people get to know you and talk with you, and you talk with them, it does not matter what about, but if they see you, if there is geographical proximity, that by itself lowers the barrier we are speaking about. How does a physician, for instance, build up a clientele? I do not

know how it happens in this country, but in England he puts up his shingle and is simply there in the community. People see him coming and going, the local grocer sees him, he appears in the streets. He joins a few clubs, and so on. He is creating proximity. People have seen him, and then when they become ill they think of him, and think they know him.

To come back to the question of setting up an alcoholic clinic, you should ask yourself why it is that the community does not invite you to come and talk to them. They have the problem of alcoholism or you would not be there. Probably they are frightened. Maybe you have horns. Perhaps you will turn them into alcoholics. They may have all kinds of fantasies. But if you appear in the local places, if they see you, see that you do not have horns, see that their fantasies are not borne out by reality, the barrier between you and them is lowered. You will find, over a period of time, that they are beginning to be interested in what you are doing. They will begin to ask questions, and one thing leads to the other. There is a snow-balling effect. It is like a snowball rolling down a hill. That is, the ball grows gradually bigger and bigger and then suddenly stops growing. Then it grows gradually bigger and bigger again, and then shows another little slump. These little slumps of the snowball, these discontinuities, occur when you have done something in the community or in the group which has aroused anxiety. In order to build up the kind of relationship that will allow you to further your program, you must be aware of the effects of everything you do in the narrower and the wider circles of the community. If what you do produces anxiety, you must work this through.

To use another model, you may have inadvertently stepped on someone's toes. You have to notice that the other person is in pain, and you have to take time out and pay attention to that and explain to them that really after all you did not see their foot there. It is too bad; you are sorry. And you will try not to step on anybody's toes again. In other words, the channel of communication from which you will ultimately get your consultation contacts is built by carefully dropping your pebbles into the pond, watching exactly where the ripples are, and making sure they are not going in the wrong direction.

Maintaining professional identification

Question

Could you ever use supervisory techniques in a consultation situation? For example, suppose you have a lone social worker in

a new area, who actually wants supervision, would you give it to her when you have been sent out as a consultant?

Dr. Caplan

This is a matter of department policy or agency policy. Certainly there is nothing terrible about supervising a lone worker, when that is the way to further professional development on the job. It might be easier to get lone workers to work out in the wilds if they had the possibility of consultation and continued supervision.

The lone worker who is a consultant in a health department has a very difficult task. Perhaps that is why you have so much difficulty getting consultants to work where there are no other people with whom they can exchange opinions. I experienced this myself in Israel. I was on my own. Whatever I was going to develop there, there was no one to whom to turn, except my own assistants who turned to me all the time. In Boston there is no lack of people to turn to. There are people to the right of you, people to the left of you, people in front of you, people behind you, people around you all the time. That makes it an exciting place to work.

We should do something about developing core groups in different parts of the country, which might be associated with training groups, universities, or something similar and which would maintain channels of communication with the people in the field, and give them support in the emotional as well as the professional aspects of their work.

If we are to make any stable advance in preventive psychiatric services, we will have to develop some program of this sort. The question is how do you go about it? What techniques do you have for enabling a core group to feed out stimulation and support to the people in the field? How long are these channels of communication? Could you have your core group in Boston, and the field people 3,000 miles away in San Francisco, 6,000 miles away in Honolulu? Or do they have to be quite close?

If the field people are very close to the core group you might have certain difficulties that you would not have if they were at a distance. If they were very close, the core group itself would belong to an agency having certain relationships of a more or less intimate nature with the agency in which the field worker is operating. If they were further away, there would be less possibility of the kind of tension you might find between a core-group institution and a health department, for example. But then if they are too far away, you have problems of communication, of the time needed to get information back and forth.

I had an experience in Israel which illustrates this. We had about 10 workers. Our core group was in Jerusalem. We had two suboffices, one in Tel Aviv, 2 hours from Jerusalem by car, and one in Haifa, a 4 hours' journey by car. But we did not have cars. Our workers sometimes had to hitchhike to get in to headquarters. Now, our workers in Jerusalem managed their mental health consultation very effectively. The ones in Tel Aviv, 2 hours away, were reasonably comfortable. The ones in Haifa were continually uncomfortable and very often broke down. Our highest staff turnover was in Haifa. The reason for this was that the Tel Aviv workers came in to headquarters every week, while the Haifa workers were supposed to come in every 2 weeks but very often something happened to transportation and they did not get in for 4 weeks.

These workers began to lose their identification with the Jerusalem group and began to identify themselves with the agencies in the field. If one of them turned up at a settlement and a teacher said: "You have to get rid of little Johnnie. He's a terrible nuisance. He's aggressive. He wets the bed," he would try to do as the teacher asked. He would lose his identity as a consultant of our center and identify himself with this poor teacher out in the wilds with a horrible little kid, and begin to act "on behalf of" the teacher.

We knew that one of these men was cracking up when we began to get urgent letters from him saying: "Please remove this child from this place." At that point, we felt we had to do something quickly for the good of the consultant. We tried sending some of our senior workers out to the Haifa area, but communication channels got mixed up and this sometimes failed. Eventually we had to close the Haifa office. We simply could not cope with the situation.

These are interesting problems. There are some things about them which we are beginning to understand. One of these is that you cannot do effective consultation, as an individual, in a complicated field situation, without having some very special strengthening devices built in institutionally. This strengthening device may be no more than that you have this technical supervision and a channel of communication with a core group of some kind. The people who do not need at least this much are few and far between.

It is easy to lose identification with your profession. This point must be borne in mind whenever a number of people are working in an interdisciplinary field. For example, social scientists in schools and universities are likely to move over with the psychiatrists and caseworkers. In the School of Public Health in Boston we must have a dozen social scientists working on different projects. We have discovered that if you want your social scientists to remain

good social scientists, you must see to it that they keep in touch with the university department of social science, or that they keep writing papers. Apparently, writing papers is a good, magical device for keeping them competent social scientists. Otherwise, they veer over and become some sort of social worker or some sort of psychiatrist. They weaken their identification with their own profession and replace it by an uneasy identification with another discipline.

MENTAL HEALTH CONSULTATION

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MENTAL HEALTH CONSULTATION

Mental health consultation, as developed at the Harvard School of Public Health, represents one approach to preventive psychiatry. It is based upon ideas and methods, some of which are familiar to most workers in the mental health field, and upon techniques which have been used for years by consultants in many different fields. My special contribution has been in developing a systematic framework, so that the different consultation techniques can be explicitly defined in such a way that consultants can be taught which techniques to employ in different cases. As a result, the whole method can be used as part of an organized program of community psychiatry.

The investigations which have led to these ideas began in 1947 in Israel. There, a consultation program was set up by the Lasker Mental Hygiene Center in Jerusalem to help the child care and educational workers of the Youth Aliyah immigrant children's organization which maintains residential institutions throughout the country. At about the same time, Lindemann, Vaughan, and their colleagues of the Wellesley Human Relations Service were developing a similar approach in a consultation program for the staff of the Wellesley School System. When I came to Harvard in 1952, the experiences from both programs were merged. During the past 4 years I have had an opportunity to try out these ideas on a state-wide scale within the framework of the Division of Mental Hygiene of the Commonwealth of Massachusetts, Department of Mental Health. This Division, under the direction of Dr. Warren T. Vaughan, Jr., maintains 16 community mental health centers on a regional basis throughout the State. Each of these centers is set up as a joint undertaking by the division and by a local citizens' mental health association. Each one provides a clinical diagnostic and treatment service for emotionally disturbed children and their families. In addition, each provides consultation services for the school systems, the child care agencies, and, in some places, the public health agencies, the courts, the police, and the probation services of the region. This work is carried out mainly by a fourth staff member, who has been added to the traditional team of psychiatrist, clinical psychologist, and psychiatric social worker. The new team member—the mental health consultant—is usually a clinical psy-

chologist by background, and occasionally a social worker. He is prepared for his new role by a 3-year course of in-service training through weekly theoretical and practical seminars.

In addition to these opportunities for mental health consultation experience, a new project was established in 1954 by the Harvard School of Public Health, in collaboration with the City of Boston Health Department, which has provided possibilities for special research. This project—the Harvard Family Guidance Center—was established in the Whittier Street Health Center of the Boston Health Department under a grant from the Commonwealth fund. It consists of a team of mental health workers, two psychiatrists, a psychologist, a psychiatric social worker, an anthropologist, a sociologist, and a mental health nurse consultant. Among various community mental health studies, this unit is carrying out research upon the ways in which mental health workers can build up collaborative working relationships with public health nurses, and upon the consultation techniques which seem most effective in helping the nurses incorporate mental health insights into their everyday work with patients.

Since the in-service training program of the State is mainly carried out at the Whittier Street Center, it is possible to make immediate use, on a widespread scale, of the insights developed in this research by communicating them to the State consultants. In turn the consultants bring back to the center the fruits of their extensive practical experience, which often serve to modify the concepts which are being developed by the intensive study. In this way, a conceptual framework has been gradually built up, which has led to the development of a system of techniques and methods. Both the theoretical structure and the practical prescriptions are being constantly altered and enriched in the light of a varied empirical experience in many different settings.

This is not the place for a full exposition of the conceptual framework we have developed to provide a theoretical background for our programs of preventive psychiatry—we have written them up in various articles, and a systematic presentation will appear in a forthcoming book—but I would like here to show very briefly how some of these ideas relate to mental health consultation. We approach the problem of a macroscopic theory of psychopathology at the community level by conceiving of the state of mental health of an individual as being a rating of his position on a scale. Optimal mental health will be at one pole and various types of mental ill health at the opposite pole. Whatever his position on this scale, the individual's state is usually one of stability or equilibrium. As he faces problems in his daily life, which threaten the satisfaction of

his fundamental needs, he may become temporarily emotionally upset during the period of problem solving. But under routine conditions, his equilibrium of functioning quickly returns to its previous state, and his rating on the mental health scale does not change. We can conceive of the forces which maintain this stability as similar to those of biochemical and biophysical homeostasis. We are aware that among the important influences are complicated interchanges which continually take place between the *intrapsychic* or *intrapersonal* forces and the *interpersonal* forces of the individual's human environment, as expressed in the social system and cultural matrix in which he lives his life.

The individual, however, is not always in emotional equilibrium. At certain times, changes in his life situation face him with problems which he is incapable of solving through the use of his customary problem solving methods. On such occasions, the homeostatic mechanisms are unsuccessful in returning him to his previous equilibrium. A more or less protracted period of emotional upset ensues which we call a *crisis*. The *crisis* is produced by the individual facing an important problem which he cannot solve during that period. It is associated with rise in his inner tension, signs of unpleasant emotional feeling, and disorganization of functioning. Eventually the *crisis* passes over, as the individual finds some way of solving the problem or adapting to a nonsolution. The signs of acute emotional upset and disorganization die down. A new state of equilibrium is reached. This may be as stable as the previous equilibrium, but the important point is that it may be at a different position on the mental health scale. This may mean that the individual is mentally healthier or it may mean that he is mentally less healthy than before.

A scrutiny of the life histories of most people, whether ill or well, will show that they have passed through a succession of such *crisis* periods. During some of these periods they moved a significant distance toward health and maturity, and during others, toward ill health.

From the point of view of planning a program of community mental health, two elements of the phenomena of these *crises* are important. *Firstly*, the outcome of a *crisis* to a significant degree is governed by the kind of interaction which takes place during that period between the individual and key figures in his emotional milieu. Their help or their hindrance may be critical in deciding whether the outcome will be that he moves toward mental health or toward mental ill health. These key figures include his family and friends, and certain professional and nonprofessional representatives of the surrounding community, whose designated or as-

sumed role is to help people in trouble. The professional workers include doctors, nurses, clergymen, teachers, social workers, and others. We call them the care-taking agents of the community. An important, but often unnoticed, part of the professional functioning of these care-taking agents is to help their clients handle the emotional problems of *crisis* periods.

Secondly, during the period of unstable equilibrium of a *crisis*, a *minimal* force exerted by one of these care-taking agents may be all that is necessary to tip the emotional balance to one side or the other—toward an equilibrium of mental health or an equilibrium of mental ill health. Once the balance has tipped over, it stabilizes in the new equilibrium. This means that minimal intervention of a care-taking agent at the height of a *crisis* may have long lasting effects on the mental health of an individual.

The implications for preventive psychiatry are obvious. If the care-taking agents of a community can be helped to intervene appropriately when their clients are in *crisis*, they may exert a far reaching effect by methods which are economical enough in time and energy to justify the hope of community coverage. It is the goal of mental health consultation that a limited number of mental health experts may be brought into contact with a large number of these care-taking agents, in order to help them intervene in a positive way when their clients are in *crisis*. In this connection, mental health consultation should clearly be supplementary to improvements in the professional education of care-taking agents. This education should systematically train them how to operate effectively in the mental health field. Pending such changes in professional education, and complementary to whatever improvements are in prospect, this consultation provides a method whereby the mental health specialist may offer skilled help to a care-taking agent so that within the framework of his routine professional functioning he may handle with greater effectiveness certain emotional problems of his clients.

Two points should here be emphasized :

1. The *emotional problems* referred to are the signs of *crisis* and not the symptoms of psychiatric illness in the client. They are the acute and temporary epiphenomena of the response to situational difficulties in the life of the client. They are not the neurotic or personality disorder symptoms which represent stabilized patterns of eventual adaptation. *Crises* will occur both in the "healthy" and in the "unhealthy" client. The ascertainment of his position on the scale of mental health is for our present purpose irrelevant. What we are trying to do is to help him move in a *healthy direction* irrespective of his current position.

2. In the mental health consultation, and in its emerging plan of action by the consultee, great care must be taken to safeguard the latter's traditional pattern of professional functioning. For example, whatever emotional help a teacher may give her pupil in his *crisis* should remain within her functioning as a teacher. It should not be that of a social worker or a psychologist. If we turn our different care-taking agents into "proxy psychiatrists", we may improve the mental health of some of their clients, but we will almost certainly distort other aspects of their professional functioning with unfortunate results. Interaction between workers of different disciplines always carries with it the danger of blurring or dedifferentiation of professional roles.

It may also be mentioned that although this consultation method focuses upon helping consultees handle *crises* in their clients, the more traditional goals of specialist consultation in this field are not neglected. Care-taking agents are likely to have their usual work complicated by unusual problems arising out of overt psychiatric illness in their clients and also out of idiosyncratic functioning based upon personality or cultural factors. They can, on the one hand, be helped to more effective professional functioning by greater insight into the psychological forces which operate in a particular work situation. On the other hand, they can be helped to play their part in a community psychiatric program of secondary prevention, by detecting early cases of emotional illness, by effective referral to appropriate treatment agencies, and by such rehabilitative management of their psychiatrically ill clients as is appropriate within the scope of their role and their institution.

Definition of Mental Health Consultation

Mental health consultation may be defined as an interaction process taking place between two professional workers, the consultant and the consultee. In the interaction the consultant attempts to help the consultee solve a mental health problem of his client or clients within the framework of his usual professional functioning. The process is designed so that while help is being given to the consultee in dealing with the presenting problem, he is also being educated in order that he will be able in the future to handle similar problems in the same or other clients in a more effective manner than in the past.

Because of its educational goal, mental health consultation can be classified as one method of in-service training. Its *opportunistic* character, however, must be emphasized in contrast with the more *systematic* approach of most other methods of training, in which

a predetermined curriculum is to be covered. The in-service training, problem-centered seminar or individual tutorial, comes close to consultation, as does individual or group supervision. Some of the techniques of the consultant are similar to those of the teacher and the supervisor. The differences are related to the facts that (a) consultation is usually initiated by the consultee in response to a current work problem; (b) the consultant usually enters the consultee's institution or department only temporarily to help deal with the presenting problem, and then retires till called in again; (c) the consultant is usually of a different professional background from the consultee, and not just a more senior or more experienced member of the same profession; (d) the consultant's role is purely advisory, and he has no responsibility for implementation of the plan to solve the work problem; and (e) the consultant is not in a position of administrative authority over the consultee.

On the other hand, the *helping* aspect of consultation brings it close to casework, and many of the technical difficulties presented by consultees in asking for help and accepting help resemble those found in casework practice. The main differences are based on the fact that the consultee is dealt with by the consultant as a fellow professional and not as the lay client of a caseworker—also by the fact that consultation is carried out in a formally recognized manner within the framework of the consultee institution, and its connections with professional task functioning are explicitly emphasized. In this connection, it must be stressed that the consultant is supposed to be an expert in the theory and practice of interpersonal relations and intrapersonal functioning. He is, therefore, expected to know more than nonpsychologically trained people about the functioning not only of the client but also of the consultee, and to base his operations in the consulting process upon this specialized knowledge. He is not, however, formally expected to make explicit his thoughts about the private and personal aspects of the functioning of the consultee, as, for instance, he would be if he were operating as a psychotherapist with a patient. This is an area of considerable technical difficulty in consultation and will be referred to in more detail subsequently.

Categories of mental health consultation

In order to decide what techniques he should use in any particular case, a consultant must assess the pattern of factors which have led to the consultee's difficulty, as well as those which have led to the request for consultation. We can deal with the former question by describing four main categories of difficulty. These

categories are found, either in pure form or in various combinations, to underly the problem faced by the consultee and to influence the types of helping technique to be used by the consultant.

1. **Help with case insight.** The difficulty is caused by a lack of insight into the nature and implications of the client's difficulties, and into the forces in his environment which are responsible for initiating and perpetuating his troubles. If the consultee can be helped, through consultation, to understand the client's situation, he will be able on his own to find ways of helping him, by utilizing his usual professional skills and the resources of his institution.

2. **Action help.** The difficulty is caused by lack of skill in the consultee or lack of facilities in his institution to deal with the special problems of the client, and by lack of knowledge or lack of opportunity to enlist the skills of other individuals or outside agencies who would be able to do so. The consultant can help by collaborating with the consultee in working out a plan of action. This may involve developing certain skills in him, developing appropriate facilities inside his institution, communicating with outside agencies, and initiating and supervising a process of referral to a special resource. One type of skill which the consultant will often be called upon to help consultees develop will be that of the better use of the self in the professional setting. Such training is still missing from the curriculum of many preprofessional educational institutions. Until it is introduced mental health consultants may well fill the gap.

3. **Help with consultee crisis.** In many cases the crisis of the client may be associated with a crisis in the consultee. This may be due to the fact that intimate association with a client facing certain emotional problems may stimulate the emergence of similar problems in the consultee, who in the past had not been able to handle them satisfactorily. This leads to a characteristic situation in which the consultee's perceptions of his client become strongly colored by his own intrapsychic complications, and become distorted and stereotyped by displacements and projections of old difficulties. The effect of this is usually that the consultee's professional functioning is specifically interfered with, and he is hindered by his own unsolved problems from helping his client. In other cases, crisis in the consultee may be found to have preceded crisis in the client, and to have been an important factor in precipitating the latter. The consultee's crisis may be due to long standing personality difficulties which have been acutely exaggerated for a variety of reasons. Or it may be due to some predominantly situational factors associated with current problems in the professional setting or in the consultee's private life. The upset in the consultee

may then light up some latent difficulties in one of his clients, who then gets chosen as a displacement object, so that the consultee wrongly ascribes all his emotional upset to his worry about his client's condition.

These ideas throw light on phenomena which are familiar to consultants who visit a variety of institutions, and who have long been impressed by the fact that different consultees and different institutions have their characteristic "sore spots"—their characteristic sensitivities to certain problems in their clients, about which they get particularly upset, and which they handle with much less than their average professional effectiveness. In a school, for instance, objective examination of a "problem child" referred for consultation will often reveal no important disturbance in the child, who has to be labeled "troubling" to the teacher rather than "troubled" in himself. If the child is removed to another classroom and to a teacher who is not sensitive in that particular way, the difficulty will cease. In the absence of consultation, however, the first teacher will very often refer some other child with the same problem, either immediately or in the not too distant future.

An investigation of the types of client referred by the same consultee over a prolonged period will often show that a limited number of core problems are repeatedly referred. In the absence of any major situational alterations, they go on repeating indefinitely despite continual change of the identity of the clients. Such a study usually reveals that although in each individual consultation there is some special consonance between the personality or life situation of the client and the problem of the consultee, the main precipitating factor is the successive stimulation of what may be called "segmental problems" of the consultee, and the involvement of the client in them. The consultee attempts vicariously to solve his problem through manipulation of the client—usually with the same lack of success which attended his handling the problem directly.

Our experience in many different settings has convinced us that consultee crisis is a significant cause of difficulty in handling the mental health problems of clients. Hence we have spent a number of years in developing a method of consultation to deal specifically with this. This consultee crisis consultation operates mainly through discussing the problems of the client with a sensitive awareness of the implications of certain aspects of the discussion to the consultee. The consultee's segmental problem is not discussed explicitly and directly in regard to himself, but once removed, in relation to the client. The emotional support of the consultation relationship is then utilized to help the consultee gain a more objective perception

of his client's problem. This usually leads to the consultee being freed to utilize his existing professional and human skills to help the client. This success has a reflexive effect on the linked problems of the consultee. Since the latter is in *crisis*, this is likely to have a quite potent effect on his own segmental problem. Such corrective emotional experience may often lead to localized personality development. It may also have a stable carryover in the consultee's future professional functioning. So when he deals with clients with this particular difficulty he may be able to use himself efficiently, instead of inefficiently. This enhanced use of the self is shown in successful cases by an increased human warmth and emotional closeness as well as by a more reality based perception in dealing with clients.

4. **Help with social system problems.** Both action difficulties and consultee crises, as well as other difficulties which lead to a request for consultation, may be directly or indirectly produced by problems in the social system of the consultee institution. These problems may be a consequence of long standing defects of structure which lead to inevitable inefficiencies in specific areas. They can only be remedied by consultation on organization, policy, and program planning over a long period. They may be traceable to relatively recent and temporary difficulties, which have led to a disorder of previously effective organization and some form of acute system disequilibrium, for which short term consultation may be appropriate.

The areas of structure and functioning of the social system of a consultee institution, such as a school, in which problems commonly occur which lead to difficulties in catering to the mental health needs of a client—in this case, a student—include the following:

a. *Communication network* either inside the school or between the school and other parts of the school system, between school and parents, or between school and outside agencies. Channels of communication may not have existed previously, e. g., to various specialist resources, or more often they have become blocked by various happenings in the system, e. g., new members of staff who are not aware that they have to pass messages in certain directions, or preoccupation of certain staff members with duties which do not allow them the time to communicate messages along certain channels.

b. *Authority system.* Unclear or ineffective leadership at various levels of the hierarchy both inside the school building and in the central administration of the school system, e. g., due to the appointment of a new principal more inexperienced and less capable than a senior "old guard" teacher, or the issuing of contradictory instructions by two authority figures such as an educational super-

visor and a guidance director, under circumstances where it is not clear who is the responsible authority.

c. *Role conflict or disequilibrium* due to a variety of causes; such as distortions of perception of complementary roles in a new member of staff or an old staff member in a new status, who in addition has not yet learned to play the role expected of him; discrepancy between personal capacity and role demands; impossible role demands due to incompatibilities of goals, i. e., where someone is called upon simultaneously to perform mutually exclusive tasks such as to be permissive and yet controlling with students, or due to being given responsibility without authority. Discrepancies between goals, e. g., between school and central administration, or between school policy and different community demands, usually lead to conflicting demands on individuals for role performance, or else to discordant role performance between individuals so that the complementarity essential for smooth functioning is upset.

d. *Personality difficulties* may upset the operation of the social system in any of the above areas. They may express themselves mainly in disordered performance of one individual who because of acute or chronic difficulties is unable to carry out his allotted tasks in the school operations, and whose disturbing influence is felt in a wide or narrow circle, depending upon his role and status in the hierarchy. Or they may express themselves chiefly in the interpersonal area due to incompatibilities between two or more individuals who upset and annoy each other to the extent that their working together is disturbed.

Short-term upsets in the functioning of the social system may lead to periods of crisis and ineffectual functioning of certain staff members, which in turn affects the system as a whole, because of disturbance in the complementarity of role functioning. Likewise, crisis from whatever cause in a staff member may disturb the equilibrium of greater or lesser areas of the school, according to the significance of his role. The effectiveness of the school organization at any time will depend not only on its basic structure and traditions of functioning, but also upon the morale or feeling of well being and cohesiveness of the staff members as a group, and the emotional state of each individual, especially those in key positions.

To help with problems in these different areas, a consultant may operate *directly* or *indirectly*. If the terms of his assignment are appropriate, he may give *direct administrative consultation* to those members of the consultee hierarchy who are responsible for managing policy. He may advise on organizational practices, on selection of personnel, and on personnel management, insofar as

these may be related to solving the mental health problems of a specific client or clients, or insofar as they may be related to prevention of such problems, or to promotion of mental health of clients and staff. In many cases, the terms of the consultant's assignment make such direct administrative consultation inadvisable. He may then offer indirect administrative consultation by using consultee crisis consultation with appropriate key persons in the hierarchy, whose individual crises may be responsible for initiating or maintaining the system difficulties. Once these key workers have been helped to return to their customary effectiveness, they can be expected to solve the system problems on their own. Or they can enlist help through institutionally acceptable channels without the active aid of the mental health consultant.

In connection with giving help in each of the four principal areas (case insight, action help, consultee crisis, and social system problems) and their various combinations, the role of the consultant will differ. For this reason it is very important that he should be explicitly aware of what his goals are in any particular situation. His task is rendered more difficult by the fact that effective functioning in one area may interfere with success in another area. For example, consultee crisis consultation with a teacher who is very upset about a pupil may be interfered with by a request from the principal of the school for direct administrative consultation in regard to social system difficulties caused by the emotionally disturbed teacher. Matters may be made more complicated if the teacher's difficulties are in no small measure due to poor leadership by the principal and if the school superintendent asks the consultant to advise on the organizational problem of transferring the principal to a smaller school.

The difficulties resulting from the conflict between procedures in direct administrative consultation and consultee crisis consultation are mainly due to the possibility of communication leaks. The teacher in crisis will have difficulty building up the relationship of trust and dependency toward the consultant which she needs in order to discuss frankly with him her problems with the referred child, if she learns or has good reason to suspect that after talking to her the consultant discusses her personality difficulties with her principal. For a number of years we have dealt with this issue by a strict policy of avoiding direct administrative consultation in order to safeguard the other type.

Lately, we have been investigating the conditions which may allow us to use both methods in the same system. One approach has been to separate one member of the consultant staff—usually a senior consultant—for concentration on direct administrative consultation,

and to free him of any other kind of consultation in that system. In one case, the psychiatric director of the agency, who has no contact with the teachers and principals of the school system, has been offering administrative consultation to the superintendent of schools. In another case, one of the senior psychiatrists has been offering administrative consultation to a public health nursing supervisor, whose staff nurses are utilizing other members of the mental health agency for various other types of consultation.

This type of approach is reminiscent of the custom, in many child guidance clinics, for different workers to treat an adolescent and his parents, or the separate marital partners in cases of marital disharmony.

In other instances, the same consultant has been attempting, on an exploratory basis, to combine both types of consultation in the same school system. This does not appear to lead to major difficulties if: (a) the consultant has worked for a lengthy period in the system, and is well known and trusted by the staff; and (b) either the culture of the system is such that fairly open communication about personal matters is generally acceptable, or there is much sociological distance, and therefore a big barrier to communication, between the administrators and the line personnel. For instance, no serious repercussions have been experienced in one school system where the same consultant has carried out consultee crisis consultation with a teacher in a school, and has simultaneously accepted the request of the district principal and the district guidance director to discuss with them the teacher's emotional difficulties and how to help her handle them. This administrative discussion took place in the office of the district principal which was situated in another school building. It was set up with the clear understanding that it was a privileged communication of a highly confidential nature.

We are quite sure that before long there will be communication leaks in some cases of this type, and we are prepared to investigate their deleterious effects on our program in that consultee system, and to see whether, and in what manner, we can remedy them. Further experience should also allow us to work out the criteria to differentiate the situations where the two types of consultation can be carried out together from those where they cannot be without jeopardizing the whole program.

In addition to the confusion of the consultant's role due to his being called upon to handle overlapping problems, his functioning is often still further complicated by the fact that he may be entrusted with other roles in addition to those of consultation. For example, he may be responsible for carrying out screening and early casefinding. Or he may be the representative of a clinical agency

which treats clients from the particular institution and he may have to collect information or impart it on behalf of his clinical colleagues. He may have certain administrative or inspectional responsibilities as a representative of a grant giving or governmental controlling agency. These various additional roles conflict to a greater or lesser extent with his fundamental roles as a consultant, and must be explicitly borne in mind in coming to a judgment as to what type of consultation method is feasible in a particular situation.

Preparing the Ground for Consultation

In order for a consultant to be able to make use of his consultation techniques, channels of communication must exist between himself and the potential consultees in their institutional setting. Relationships of an appropriate nature must have been built up, and must be maintained, between his agency and the group of consultees. Also, there must be a suitable organizational structure within which the consultation can be requested and delivered. A fairly lengthy period is usually needed in order to develop these relationships and arrangements, and an essential aspect of the training of consultants is focused upon equipping them with the knowledge and skills needed to build up this framework through a process of community organization. Much experience has taught us that a consultation program will often stand or fall not on the basis of the content of the individual sessions between consultant and consultees but upon the success or failure of this community organization process.

Among the points which we have found to be significant are the following:

1. The simplest organizational pattern is for the consultant to come into the consultee institution from the outside. This may be in response to a request for consultation, or on regular scheduled visits to receive consultation requests. His base of operations should be outside the consultee institution, and his home agency should be administratively separated from the latter. Payment for his services should be by annual contract to his agency. In the case of State services there may be no transfer of funds. Nevertheless a contract should be drawn up, since this formalizes the official sanction under which the program will operate. Many of the operations of a consultant are of a highly unstructured nature, so this top sanction is a matter of considerable importance.

The main reason for emphasizing a pattern in which the consultant is an officially invited outsider in the consultee institution is

that it gives him the opportunity to act, and to give the appearance of acting, without bias. When he enters, he becomes the focus of complicated social forces. The different pressure and interest groups perceive him or attempt to manipulate him to fit in with their conflicting goals. As an outsider, he is better able to resist these pressures and to maintain a friendly neutrality, as well as a broad field of objective scrutiny in assessing the forces at play. A second reason, closely linked to this, is that he can convey more potent messages if he has no set place in the social system which would inevitably close certain channels of communication to him, and might open such others as would disturb his freedom to make certain privileged communications to people of his choice.

We have so far had very little experience of workers using our methods of consultation, who have been staff members of a consultee institution. A mental health consultation service, however, is about to be organized as an integral part of the operations of a large city health department in Massachusetts. We are looking forward to this opportunity to see what problems develop.

2. The question of sanction for consultation operations has already been mentioned in connection with the contract which is negotiated at top administrative levels. We have found, though, that this is not the only sanction needed. Permission to operate the service has to be negotiated at all levels of the administrative hierarchy. This is not only important in starting the program, but it has to be continually renewed as the program continues to operate. A consultant working in a school, for instance, must make sure that he has regular contact with the principal and other authority figures whose permission and support is needed for the continuation of his program. In addition, he must spend a little time every now and again with the superintendent of the school system, the supervisors of education, and the heads of the guidance and perhaps health departments. The amount of time and energy to be devoted to this "sanction maintenance" activity will vary from one system to the next, but in each system there will be a minimum below which the program will be jeopardized.

3. Experience shows that in the initial stages of interaction between a consultant and a potential consultee institution, the first members of the latter's staff with whom contact is effected are often peripheral to the core group of the institution, or are deviant in some way. For instance, in one place an emotionally disturbed teacher who had a long history of chronic difficulties with her colleagues was the first to phone the center and ask for consultation. In another case, a teacher who had not been satisfied

with teaching history and had arranged to take on part-time guidance work—a plan which had been permitted by the principal with some ambivalence—initiated the contact with the consultant. In many cases where contact is initiated from higher levels of the administration, e. g., by a directive from the superintendent of schools, the consultant is asked on his first visit to consult with the newest and least experienced teacher on the staff. In other instances, when the consultant first appears a minority clique of the staff tries to monopolize the interactions with him. Often this occurs without much opposition from the majority, who may view his entry with disinterest or even suspicion.

A consultant anxious, and sometimes overanxious, to get embarked on interaction in a new institution may welcome the outstretched hands. But with experience, he will learn that if he builds up too close a relationship with these first people, he may later find that he has been classed by the central staff group as peripheral or deviant himself. He may sometimes get into even more serious difficulties when he finds that by allowing himself to be drawn into a corner of the institution he has failed to obtain adequate sanction at the successive upper levels of the administrative hierarchy, because of tensions between the authority figures and his "friends," which have led to closure of certain channels of communication to him.

Such experiences have taught us that although initial entry into an institution must often be made in an opportunistic manner as a result of invitation by a peripheral member of the system, an essential early goal is to map out the authority pattern of the institution and to work as quickly as possible toward contacting all the key figures in order to explain the program and obtain their approval.

4. The pattern of arrangements for consultation should be such as to allow the most direct access to consultees when they are experiencing difficulties with their clients. Consultation should not take place through intermediaries. For example, classroom problems are best discussed with the teacher, not with the principal or the guidance counselor. The time, place, and person should be as close as possible to the problem. This not only allows the consultant to obtain an undistorted view of the forces at work, it also allows him to exert a maximally effective influence in tipping the balance in a crisis situation. The mental health consultant needs his information "hot." He can be most helpful when he can react immediately to it. Then he can capitalize on the mutational forces of crisis.

This goal, however, must often be achieved in the face of two sets of obstacles:

a. During the initial stages of building up channels of communication to obtain sanction from the leaders of the institution, they may not trust the mental health consultant to the extent of allowing him this freedom. Principals are often worried about the "dirty linen" he may unearth if given direct access to a disturbed teacher. Or they may wish to protect the teacher from the possible harm which they imagine he may do her with his "new fangled psychological tricks." Guidance people may have feelings of rivalry with the outsider. Fearing his function may overlap and replace their own, they may block direct contact between consultant and teacher by offering to "work up" the case systematically and present him with a "full report." Such obstacles can rarely be bypassed or broken through with impunity. When they exist, the consultant must realize that he will only be able to employ his consultation techniques after he has succeeded in demonstrating to the leaders by a patient process of interaction that they can trust him. This often takes quite a time.

Of course after a consultation session with a teacher the consultant may feel it is advisable to discuss the problem of the client also with the principal or the guidance counselor in order to maintain their interest and support. This will always be cleared with the teacher, who may need to be assured that these discussions will focus on the client and not upon his own handling of the case.

b. Much of the important information about the situation in an institution and about the forces at work in a particular consultation problem can be obtained through the consultant's awareness to the details of the arrangements which the leaders of the institution and other staff members make for his reception and the conduct of his work. The details of the roles which are projected upon him, and the ways he is manipulated in interpersonal contacts, will tell him a lot about the consultees and their institution. Especially if he comes in during a consultee crisis or system disequilibrium situation, this knowledge can be invaluable and hardly obtainable quickly enough in any other way. This means that apart from defining certain limiting aspects of his functioning, the consultant should studiously refrain from imposing any preordained pattern on the arrangements for his working. Instead, he should allow the consultees to set up the situation in their own way. Once he learns what their pattern is, the consultant can decide how much and in what ways he will try to alter it in order to give himself the best working conditions. But this should be done cautiously, and with an explicit awareness of possible unwelcome consequences.

Consultants very soon learn that the working arrangements and the general aspects of the social structure and culture of an institution have among other goals the purpose of acting as a collective system of unconscious defenses to protect its members from their common anxieties. His entry into the institution, especially if it occurs at a time of trouble, may well be initially a source of extra anxiety, even though his explicit role is to be helpful. An essential feature of our mental health consultation techniques is that they are designed to operate with as little interference as possible with existing defenses, whether of the individual or of the group. In this way less resistance is aroused. Maximum results are obtainable in the shortest time—at least under conditions where a crisis problem has brought important forces to the surface of awareness, and where rise of tension has stimulated mobilization of individual and group resources.

5. A fundamental aim which guides much of a consultant's operations in the process of building up a working relationship with the consultees is that of ensuring the development of congruent perceptions of each other's roles. The consultees have to be helped to get to know him as a potentially helpful professional worker and as a trustworthy human being. We have found that this is not nearly as simple a process as it may sound. Also, it takes a much longer time than one would expect. I am referring particularly here to the dissipation of general stereotypes which distort perceptions of an outsider whose professional role is new and not yet accepted, and not merely to the specific distortions due to transference of roles and expectations that are a result of the consultant being involved in the fantasies and emotional complications of a crisis problem. One consultant, a psychiatrist, was rather surprised, for example, when a nursing supervisor, with whom he had been working in close and friendly relations for 2 years, said one day at a meeting, "You know I have only recently discovered that often you psychiatrists don't know the answers yourselves to the questions you ask me. I have only just got over the feeling that whenever you talk to me you are psychoanalyzing me and trying to catch me out!"

The more possibility there is for interaction between consultant and consultees in connection with items of joint experience, and the more consistent is the behavior of the consultant, based upon his explicit awareness of his own role, the more opportunity there is for the consultees to test the limits of his functioning and to develop a reality based set of perceptions of him.

This is not a one-sided process. It is important for the consultant on his side to be aware that he has the task of getting to know the consultees. In so doing he can understand and respect them as fellow human beings and as colleagues of a sister profession.

6. We have learned that certain arrangements in a consultation program can be altered in order to promote consultations of certain types and discourage others. This can be done in a planned way in line with the current policy of the consulting agency. The threshold between consultant and consultees can be raised or lowered by changing his visiting times or the type of his interactive behavior on the occasion of his visits. For instance, in order to foster consultations when consultees are most insecure or when they are feeling ashamed or guilty, or on the other hand, when their felt need is minimal, the threshold can be lowered by more frequent visits. It can also be lowered by the maneuver of "creating proximity," i. e., purposely arranging to be within talking distance of the consultees, e. g., in the corridors, the cafeteria, or the rest room. Regular interactions explicitly set up to achieve some nonthreatening joint goal, such as interviews to discuss some research project in which the consultant is interested and in which the potential consultee is willing to be of help, are another useful method of creating proximity. The sharing of joint experience, and the frequent practical opportunities for talking together, are some of the important factors in facilitating the development of the friendly trusting relationship which lowers the consultation threshold.

On the other hand, a consultant who has a big geographical area to cover may decide, in line with the policy of his agency, to operate only in cases of major consultee crisis. He will then be well advised to increase the distance between consultees and himself. This can be done by infrequent visits to an institution after he has built up appropriate channels of communication. He should also arrange his visits mainly in response to urgent calls for help. The state of the crisis can be assessed by the degree of urgency of these calls. An attempt can be made to delay the visit till the climax of the crisis, so that the consultant arrives just in time to help tip the balance. Of course this is a tricky business. A miscalculation will mean arriving after the peak of crisis has been passed and after the fateful decisions have already been made. The visit of the consultant will then be something of an anticlimax! Experience in Israel, where we had to cover the whole country with a small staff of consultants, convinced us that such a policy is practicable, but of course it often fails. In any case it relies on the presence of

alternative methods of crisis reduction in the system, so that if the mental health consultant does not turn up, some other care-taking agent or agency will step in to help with the problem.

7. It must be clear from much that has gone before that most consultation is carried out in short series of interviews at periods when a particular consultee is experiencing a problem, and not, like education or psychotherapy, for example, in lengthy series of meetings which are scheduled well in advance. The average number of consultation visits per consultee problem in most of our work has been 3 to 5. At the end of that time the consultant ends that contact. It is essential though that he should not only not end his relationship with that consultee, but that he should take active steps to keep the communication channel open between them. He does this for two reasons: (a) to facilitate being called in by the same consultee for fresh consultations in the future; and (b) to evaluate the effect of his consultations by followup visits.

The question of evaluation of mental health consultation is even more complex than most problems of evaluation in the health field in general and the mental health field in particular. Neither the feelings of the consultee about the consultation, nor the condition of the client after the consultation, are adequate bases for this evaluation if we accept the fundamental goals of mental health consultation to be the duality of help plus education. The only logical basis must be an assessment of the *future functioning* of the consultee in handling similar problems in the same client or in other clients. This can only be determined by a prolonged followup study. We have begun to carry out some preliminary evaluation of consultee crisis consultation. In those cases where successive series of consultations appear to lead to positive results, we find we can trace out a characteristic succession of phases. At first the same problems recur and provoke the same intensity of consultee crisis. Later the consultee requests help with similar problems. His emotional reaction, however, is less intense and so is the interference with his optimal professional functioning. Finally he discusses cases with a focus on the original topics. But now he is doing so out of human interest and involvement. There is no personal upset which interferes with his professional efficiency. If the followup shows a consultee who appears never to have clients with the original problems, we get suspicious that he is dealing with his difficulties by denial and avoidance. This implies a failure of the consultation, the goal of which is to foster the human proximity of consultee and client but to relieve the distortions in the personal involvement.

Building Up the Individual Consultation Relationship

Whatever the type of mental health consultation, its success is in considerable measure based upon the quality of the emotional relationship which has been built up between the consultee and the consultant. The importance of this relationship is least in case insight, most in consultee crisis, and intermediate in action help and administrative consultation.

The consultation relationship is energized from the side of the consultee largely by the latter's emotional involvement with the client and his problem. It is this involvement which motivates the initial request for consultation and brings the consultee into contact with the consultant.

There will be difficulties in establishing the optimal consultation relationship under two sets of conditions: Whenever (a) the consultee's involvement with clients is generally low (e. g., in high schools, where each teacher has teaching contact with a great many children and there is little formalized direct link between one teacher and one child, as in elementary schools); or if a problem is easily sidestepped by referral or denial (e. g., a public health nurse with an overload of cases, who may just not bother to make home visits in certain difficult cases and may throw the responsibility onto the patient for initiating contact, unless she has a statutory obligation to persist in seeking out the patient, as for example in TB cases); or (b) personal emotional problems of the consultee obtrude and displace work involvement, i. e., the consultee becomes primarily self-oriented instead of task-oriented, and on the one hand may demand personal service in the form of psychotherapeutic help from the consultant instead of work centered consultation, or on the other hand may avoid asking for help because of unsolved dependency problems.

The degree of emotional involvement of the consultee has always to be carefully assessed by the consultant in the early stages of the relationship. He will be guided among other signs by the following:

a. Preoccupation with the importance of the client's problem in comparison with other routine aspects of the consultee's daily work.

b. Degree of empathy or identification with the client's predicament. Worry about the consequences to the client.

c. Signs of personal tension, and verbal expressions of personal anxiety, shame, guilt, and sense of failure at the inability to deal with the client's problems.

d. Amount of initiative, activity, and self mobilization in handling the difficulty. This will be associated with the intensity

of searching for the help of others including the consultant, and the degree of demand upon him for assistance.

In assessing the consultee's emotional involvement, the consultant will be particularly interested in whether this is sufficiently intense to be definable as a *crisis*. This definition is always an arbitrary one, and represents a judgment by the consultant dependent upon his assessment of a cutoff point on a gradient. The following criteria of crisis are used as a guide:

a. The degree of emotional involvement of the consultee is beyond what would in general be expected from such a personality in such circumstances.

b. High tension in the consultee is not associated with self mobilization and greater effectiveness, but with lesser professional efficiency than usual for that consultee.

c. Marked stereotyping is present in the consultee's perception of the client and behavior towards him. This has to be rated for intensity according to the following criteria:

- (1) Reality—the degree to which the perception reflects or departs from reality as objectively assessed by the consultant.
- (2) Persistence—the duration of the period of time over which the perception is maintained unchanged.
- (3) Exclusiveness—the degree to which one perception is held to the exclusion of all others.
- (4) Intensity—the amount of affect attached to the perception, and the degree of intensity with which the perceived quality is felt to exist in the client.
- (5) Clarity—the oversimplification of the outline of the perception.

From an assessment of all these criteria, the consultant will be able to judge what the consultee brings into the relationship initially. Then he can decide what active steps he should take in promoting the consultation relationship. From the side of the consultant this should always be an active process. He may be active in assisting the consultee to ask for help, e. g., by creating proximity and lowering obstacles to consultation. He must be active in building up an atmosphere which encourages a positive, mildly dependent relationship on the part of the consultee. Until this relationship is established, he should be cautious about reducing the anxiety level of the consultee, since in the initial stages this is the force which holds the two together. Reassurance, i. e., the direct lowering of anxiety by suggestion, in the early stages of the contact reduces the consultee's felt need. If he has not yet developed a meaningful emotional relationship with the consultant he will often break off the contact.

On the other hand, the consultant must be tactful and sensitive to the strain under which the consultee is laboring. He must not allow the latter's anxiety level to rise too high, because this may be construed as a rejection, which will then effectively block the development of a positive relationship. The technique which is most useful in keeping the consultee's anxiety level at an optimum is to avoid reassurance and to get him to agree to a joint examination and clarification of the problem. The consultant offers his help and support and then "plays for time," during which he will have a chance to build up the relationship. In carrying out this maneuver, the consultant must avoid being infected by the consultee's sense of urgency and panic. Also, he must aim at delaying a decision concerning action. Experience shows that his own lack of anxiety when facing the problem, and his active involvement with its promise of support, are sufficient to keep the consultee's excitement within manageable limits, as long as he does nothing to weaken the latter's existing defense mechanisms.

The consultant's expressed attitudes to the consultee are of prime importance. He should show him the respect of one professional person to another. He should avoid the development of too dependent or regressive a relationship by placing a continual tacit stress on the consultee's responsible adult status. He should avoid as much as possible being manipulated into a God-like omnipotent role, and should be modest and nonauthoritarian in manner. On the other hand, he should be outspoken in his offers of help within the limits of his professional role, and should give a practical demonstration of his good intentions by his patient efforts at clarification and understanding of the consultee's difficulties. Needless to say, he should make his fundamental attitude of acceptance and absence of moral criticism very obvious from the beginning.

Consultants with experience in casework or psychotherapy find all this reasonably simple. They have much more difficulty extending these attitudes to their contact with the social system of the consultee's institution, since their own cultural prejudices are unlikely to have been as adequately remedied in their past training as their individual psychological blind spots.

This approach of active and sympathetic effort to understand the consultee's problems and to help with his burdens acts as an offer on the part of the consultant for acceptance by the consultee as an accessory ego figure. Although direct reassurance is avoided, except where the consultee is panicky and in danger of breaking into impulsive and desperate avoiding action, the acceptance of this type of ego support from the consultant leads to a lowering of anxiety and tension. This is mainly due to identification with the consultant

and his own lack of anxiety in the face of the problem. This bond not only makes the consultee more comfortable, but creates a situation in which he can learn readily from the consultant. It lays the foundation for the consultee also to accept the consultant as an accessory ego-ideal figure—namely the consultee unconsciously adopts certain values of the consultant in his approach to the client's problems. The consultant makes conscious use of this by taking care to demonstrate by implication his own human, sympathetic, but objective attitudes towards the client, with the expectation that some of these will be picked up and taken over by the consultee. This is an area where consultants have to operate with care or they may distort the consultee's professional role identity. It is easy for the consultant to portray not a "human" approach to the client, but a psychiatrist's or a social worker's approach, and the consultee may partially adopt these specialized attitudes.

The third aspect of the consultation relationship is that the consultant may be accepted by the consultee as an accessory super-ego figure. Since the consultee is often feeling guilty about his failure in dealing with the client's problem, he expects punishment from the consultant in the form of criticism or blame. When the consultant becomes a key figure for him as a result of the deepening of the relationship, his not blaming, despite his active getting to know the circumstances of the case through detailed discussion, relieves this guilt. This very often leads to a considerable reduction in tension and increase in effectiveness on the part of the consultee. The acceptance of the consultant as an accessory superego figure depends not only on his behavior, but also on his status. He must be perceived as an authority figure. This is another reason in favor of consultants not being part of the administrative hierarchy of a consultee institution, so that they may be perceived as being of high status by virtue of their professional background, and not be pegged to a fixed position in the hierarchy. This point should also be borne in mind in deciding which members of the staff of the mental health agency should offer consultation to the upper echelons of the consultee institution.

Psychosocial Assessment of Consultation Situation

This is important in all mental health consultation, though more so in consultee crisis consultation.

Information is gathered from all socially acceptable and expectable sources—e. g., from direct questioning without infringing on expectable behavior of the consultant role, collateral information from past contacts with the community, the culture, the institu-

tion, and the consultee either by the consultant himself or his colleagues is valuable.

The important question is—Why does this consultee in this institution at this time refer this particular client's problem to me? Every word of this question should have equal emphasis.

Apart from direct verbal inquiry, the consultant must make major use of observation of cues of interpersonal behavior and of his empathic understanding of the feelings of the consultee for his client, for his colleagues in the institution, and for the consultant. The last is very important. Especially is this true in consultee crisis consultations where the consultation relationship may be made an accessory vehicle for expression of the consultee's problem, i. e., the consultant acts as a new displacement object auxiliary to the client.

The assessment of the problem situation if complete should include, e. g., in a school:

1. Factors in the child in his adaptation to his intrapersonal problems and their interaction with the social and work situation in the school, and with his present life situation at home.
2. Factors in the classroom in respect to the group situation vis-a-vis the teacher and pupils, and also the work demands of the curriculum.
3. Factors in the teacher in respect to his basic personality and style of functioning, and recent problems in respect to intrapersonal difficulties and adaptation to the culture of school, relations with colleagues and superiors, and life at home and outside the school.
4. Factors in the social system of school relating to traditions, value system and general culture, and also to its present social structure with reference to authority system, communication network and morale.
5. Factors in the community insofar as its political and cultural forces impinge significantly on the school at that time.

In a complete assessment, the dynamic interrelations of these factors, as they operate both overtly and covertly, and impinge upon the consultee and the client, must be stated in a meaningful way. Because of the realities of consultation, this assessment will never be complete. Gaps in the pattern, due to *inevitable ignorance* because of the nonsystematic opportunistic gathering of data, are always present. The experienced consultant must learn to make intelligent guesses to fill out the pattern. He must always keep his mind open to collect more data. He must maintain flexibility to alter parts of his pattern to conform with the new data.

Assessment is a never ending process throughout consultation. It consists in advancing a series of hypotheses which should be

explicit in the mind of the consultant, and which he should be constantly testing against the data he is actively collecting.

Training in consultation concentrates particularly in teaching a consultant how, on the one hand, to play for time at the beginning of a consultation, in order not to build a psychosocial assessment pattern too much out of his own imagination before he has had time to collect sufficient situational information, and, on the other hand, to be willing to "stick his neck out" and hazard an informed guess, before he can be sure he is right. The process is similar to that of making a differential diagnosis in medicine, except that the avenues of explicit systematic exploration may be closed by the circumscribed nature of the consultative contract, e. g., the consultant is hired to deal with the mental health problems of a client, and he may, therefore, not be expected or permitted to ask specific questions about the private life of a consultee, or about the secret tensions between factional groups in the institution.

Special Techniques

1. Case insight

The technique of case insight needs little special comment. The most important point has already been mentioned, namely that the increased understanding given to the consultee by the consultant should be of those aspects of the psychological functioning of the client which are appropriate to the professional framework of the consultee. Psychological or psychiatric terminology should be avoided as much as possible. The main emphasis should be upon trying to understand those aspects of the client's behavior which focus upon his functioning in the content of the consultee institution. Specialist investigation of the client by the consultant, by means of tests and so forth, should be carried out only under exceptional circumstances. Joint observation of the client by consultant and consultee is a useful procedure, however, since it affords the possibility of a discussion of a common experience at a level of discourse which comes natural to the consultee.

2. Action help

The consultant in this type of consultation should be quite active himself in finding out what facilities exist in the institution and in the surrounding community in order to help the client. He should, however, keep to a minimum the giving of direct advice, at least until he has found out what the consultee has to offer. His role is to help the consultee work out his own plans within the framework of the functioning of his institution. Consultants who have little initial knowledge of the detailed operation of a con-

sultee institution will usually be pleasantly surprised. They will develop a healthy respect for their consultee colleagues, if they will have the faith to act as supporters and clarifiers while the consultees work out their own characteristic plans, instead of superimposing the plan of a mental health specialist. In any case the latter can be kept in reserve should the consultee's plans fail. The consultant should aim to help the consultees review a variety of possible alternatives for action. Also he should assist them in setting up a program to try them out in a systematic way in order to find out from experience which works best.

As a consultant gains more experience within the setting of a particular consultee profession, such as teaching or nursing, he will be able to add to the discussions with the consultee a list of ways which other teachers or nurses have found to be helpful in similar circumstances. He can then leave it to the consultee to choose the path which the latter feels most appropriate to his own situation.

3. Consultee crisis

The main techniques are segmental tension reduction and dissipation of the stereotype.

a. *Segmental tension reduction.* This technique consists of the consultant determining which particular aspect of the client's problem is specifically linked to a segmental problem of the consultee, and then discussing this problem in a relaxed and reality-based way so that the consultee, in identifying with these attitudes, will lose some of his exaggerated fear or guilt about the topic. This may be done by discussing the client directly. In certain instances it can be done by talking about some other case that the consultant has known—in effect, by telling a parable. The important aspect of the technique is that the tension reducing messages are best communicated by implication and not in explicit form. For instance, in the case of a teacher who is upset by a child of 8, whom she stereotypes as out of control and liable to burst forth into violent and dangerous activities, the approach which would be most likely to calm her own fears of loss of control over instinctual impulsivity might not be to point out the ease with which an adult can control a child, but to help her see that some of the child's difficulties stem from his fear of abandonment and his attempt to provoke nurturing interaction from the people around by his overactivity. This approach deals with the question of control as a side issue. The implication which the teacher may pick up is that even a child of 8 can control his hostile impulses if he finds some way of satisfying his basic needs for love. The dramatic nature of the child's hostile behavior need not worry us too much. It is only a secondary issue

which can easily be handled if a solution for the central problem can be found. This is likely to be much easier for this teacher to accept than a direct attack on the problem of loss of control, which is so frightening to her.

b. *Dissipation of the stereotype.* This technique is closely allied to the previous one. It consists of the consultant drawing the attention of the consultee to individual aspects of the client, either during joint observation of the latter's activities or in a subsequent discussion. He involves the consultee in a joint search for the special human meaning of the client's reactions. In this discussion, the consultant at first puts forward his own personal perceptions of the client and little by little encourages the consultee to do likewise. The consultant takes care to use the consultee's language and not his own professional jargon, since his aim is to promote the psychological closeness of consultee and client.

Where this maneuver is successful—and sometimes it takes a few interviews to accomplish—the consultant becomes aware of a quite sudden and dramatic change in the consultee's manner. Many workers describe a "kind of click" that occurs and suddenly the consultee's perception changes. Sometimes this "click" is accompanied by expressions of surprise on the part of the consultee similar to the feelings expressed by an analysand after a mutative interpretation as described by Strachey.

Two other aspects of the technique of consultee crisis consultation are worthy of mention:

a. *Solving the client's problem.* As soon as the consultee begins to perceive his client in a realistic manner, undistorted by stereotypes projected from his own intrapsychic problems, he becomes as efficient a practitioner in this as in his other cases. The role of the consultant is then to stand by and to interfere as little as possible as long as he feels the consultee's relationship to his client remains free of tension. At this stage of the joint endeavor, the consultant has the best opportunity of weaning the consultee toward independence, since the latter derives considerable gratification and increased self-esteem from being able to solve his previously insoluble problem. Moreover, there may be a specific increase in stability in his own personality. This is his own problem he is solving, "once removed" in his client.

b. *Techniques for avoiding psychotherapy.* The avoidance of psychotherapy is one of the cornerstones of this consultation method. There is awareness of the personal implications of the consultee's difficulties in his work, but the latter and not his intrapsychic conflicts are the focus of the consultation process.

Throughout the consultation contact, it is made implicitly, and if necessary explicitly, clear that the consultant's role does not include handling the private personality problems of the consultee. There is no attempt to deny the existence of such problems. Whenever they are brought up by the consultee it is emphasized that they cannot be dealt with in this context. The consultant expresses his belief that whatever their nature, it is likely that the consultee can control them to such an extent that they need not prevent his handling the client's problem. If, on the other hand, this reassurance appears—as on rare occasions it does—ineffective in stilling the consultee's expressed wish for personal help, the consultant will offer to refer him to another institution for psychotherapeutic service. Such referral would not be made until it was seen that the help derived by the consultee from the consultation process was ineffective in quieting his anxieties. The consultant's attitude is that everyone has intrapsychic conflicts and that the usual way of dealing with them is by working them out in real life. If this process fails, there are facilities for psychotherapy and psychoanalysis to which a person may turn for help, if he is sufficiently motivated.

A point of some difficulty is how to avoid dealing with the consultee's request for help with his own problems without making him feel rejected, which would damage his positive relationship with the consultant. The way in which this is done is to turn the focus back onto the consultee-client relationship. This can be done by emphasizing that the consultant's experience with the problems of his own personality has probably developed in him sensitivities and strengths on which he may capitalize in the service of his profession. The usual reason for his raising the point is his worry that his problems are interfering with his job. The consultant stresses the positive aspects of the situation while implying that the consultee like everyone else is entitled to have emotional symptoms and need not feel ashamed or guilty about them. Instead of accepting the consultee's invitation to analyze and attack his symptoms, the consultant tries to get him to be more tolerant of them, and tries to strengthen rather than weaken his neurotic defenses.

In the majority of cases, a consultee does not bring up his intrapersonal problems, since the consultation process is so obviously focused on the interpersonal relationship with his client, and on the latter's personal difficulties. It is this focusing which makes the process so safe and avoids the arousal of the resistances which are the inevitable consequence of the psychotherapeutic process. Because of this focus, there is no attempt to give the consultee insight into what has been happening in his difficulties and in the consultation which has resolved them. Such insight might be supposed to

stabilize the result of consultation. But it may paradoxically have the negative result of making the consultee afraid to involve himself in the future with clients and consultants who may trigger-off his unsolved conflicts and disturb his psychic equilibrium.

After a number of successful consultations, a consultee will develop a greater tolerance of emotional expressions in himself and his clients, but this rarely amounts to real insight into the details of what is happening to him in any specific case.

The importance of avoiding psychotherapy from a practical point of view is that it allows consultation to operate with a minimal arousal of resistance and at maximum speed. Although its results are not as far reaching as those of psychotherapy, they are often quite stable in the narrow segments which are dealt with. In other words, it is just this point which makes consultation appropriate in the context of a preventive program.

4. Direct administrative consultation.

This is the area of mental health consultation about which we have least experience so far. A detailed discussion of techniques must await further exploration. In planning for this exploration, we are interested in determining the special contribution which can be made by mental health consultants, who are familiar with the unconscious aspects of intrapersonal and interpersonal functioning and also with the fundamental psychological needs of people, as compared with the contributions of administrators or social scientists, whose expertness lies more in the area of organizational structure and group functioning.

We are also interested in defining the boundaries of administrative consultation, which may have to deal with problems of different interest groups among personnel, on the one hand, and mediation, which attempts to reconcile discrepancies of goals among conflicting groups, on the other hand. Here, as elsewhere, it appears that the functioning of the consultant differs from that of the worker in closely allied fields on the basis of differing definitions of their roles as expressed in the framework of the requests for service and sanction for operations contained in their respective contracts. An interesting question which might advance knowledge in many of these fields would be whether there is not a generic fund of theoretical and technical knowledge which is widely applicable, and whether it may not also be possible to discover the principles governing the specific variations in some of these specialized fields.

SOCIAL WORK CONSULTATION IN PUBLIC HEALTH

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THE HISTORY OF THE
CITY OF BOSTON

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JOHN H. COLEMAN
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SOCIAL WORK CONSULTATION IN PUBLIC HEALTH

In this presentation we will be concerned specifically with the process of consultation as carried out by the professional social worker in a public health setting—a professional person whose training has prepared him to understand and to use social work processes, particularly the process of social casework to help patients and families with psychosocial problems related to health and disease. Through training and experience this professional person—the social worker—has a knowledge of clinical settings and the techniques required to work on a multidiscipline basis. His experience in social casework has been sufficient to enable him to help other professional people who are not social workers to use some of this knowledge in their own professional practice.

This social work consultant is a part of an agency whose primary goal is prevention of disease. Its responsibilities may include secondary prevention as well as primary prevention—medical care as well as sanitary engineering, child guidance clinics and pediatric clinics as well as child health conferences. Its work involves a multidiscipline approach to health problems in the individual and the community. Although the details of administration in public health agencies differ, their organization is similar since their goals and responsibilities, many of them based on law, are similar. The social worker, like other members of the staff of the public health agency, functions in accordance with the goals, responsibilities, and organization of his agency.

Consultant Role in Social Work

What are the characteristics by which we can recognize the consultant role in social work as we observe it in the public health setting? The definition and principles of consultation that follow are applicable to other disciplines and to social workers in other settings but they are not universally accepted by all disciplines in all settings.

Most social workers in public health would agree that consultation has the following characteristics: Consultation is a helping

process which involves the use of technical knowledge and professional relationships with one or more persons. Its purpose is to help consultees to carry out their professional responsibilities more effectively. It takes place within a framework of administrative arrangements which set up the responsibilities and the channels of communication to be used by consultant and consultee. Consultation is given upon request from the consultee and he is free to accept or not to accept suggestions made by the consultant. The consultant has no responsibility for direct action with regard to the problem and is not responsible for the actions of the consultee.

Consultation resembles casework in many ways. It calls for utilization of much of the same content. This content is based on knowledge of psychosocial factors in individual and family situations and of community resources to meet the needs of these individuals and families.

Consultation may involve use of many of the same techniques as casework but when these techniques are used in consultation, they are used selectively. They are applied only to the extent that they are appropriate for a relationship whose aim is to help the consultee with his professional problem—a relationship which is not set up to give direct help with personal problems.

Administrative or supervisory responsibility is incompatible with maintenance of a consultative relationship. If problems exist in this area, they usually occur when the consultant assumes or allows himself to be maneuvered into a supervisory role. We know of no social work consultants in public health who are expected to prepare the performance rating of consultees.

Problems do arise in distinguishing between consultation and collaboration or cooperation. Sometimes, perhaps, this may be due to an idea that the word *consultation* carries greater prestige. This is understandable if we think of consultation as connoting "authority of knowledge" and collaboration or cooperation as involving joint responsibility for direct service. In the practical realities of position classification, direct service is often awarded less prestige and less remuneration.

Collaboration is the carrying out of direct services by two or more professional people working with the same case or in the same situation. When a doctor, a nurse, and a social worker are all giving direct service to a patient or are all trying to plan a program by which the agency in which they are employed can meet certain needs in the community, they are collaborating. When a social worker in a health department confers with a social worker in the welfare department about a case to which they are both giving direct service, this is cooperative casework. Casework service im-

plies responsibility for direct action which is incompatible with the consultation relationship.

Although consultation may employ some educational techniques, it differs from teaching. The consultant does not have responsibility for instruction on all aspects of the consultee's job but only for those aspects which are related to the problem with which the consultee wants help. Personal involvement of the consultee in the problem is basic to the success of consultation. Case material presented in a teaching situation, even case material in which one person in the student group is involved, does not provide the framework for the same kind of helping relationship as consultation. In both teaching and consultation, discussion is used to clarify the situation and identify the problem being presented, but the focus differs. The emphasis in teaching is on principles and techniques; the emphasis in consultation is on helping the consultee to find a workable solution for the specific problem under consideration.

Types of Consultation

Two general categories of consultation exist—case consultation and program consultation. These can be divided for purposes of discussion. In practice it is often desirable for a consultant to use both. Case consultation frequently provides information which is helpful in strengthening program consultation.

Case consultation

In case consultation the social work consultant focuses on helping the consultee to understand and to deal more effectively with psychosocial factors related to health and disease in individual case situations. The personality of the individual patient, his family relationships, his social relationships in the community, his school, his job are all considered. The case consultant sometimes gives specialized information which helps the consultee. Through discussion of the case situation, the consultant often gives help to the consultee in relation to attitudes and feelings of the consultee which may have an adverse effect upon case management. Frequently, the social work consultant is expected to make explicit suggestions about the handling of cases. In most instances, he is expected to help the consultee of another discipline to identify social needs and social pathology in case situations and to plan for referral of such problems for social treatment. This may involve the giving of information about social services and social agencies, assistance in selecting appropriate social services, explanation of methods of

referral, and help in understanding how to cooperate with social workers in other community agencies.

A social work consultant might, for example, give help to a consultee in relation to an unmarried pregnant woman under care of the prenatal clinic. Through discussion of this situation, the consultant might help the consultee to achieve a more positive relationship with the particular patient through dissipation of a stereotype about unmarried mothers. The help given to the consultee in understanding his own feelings about the unmarried mother in this case should assist him in establishing a more effective professional relationship with other unmarried mothers.

The social work consultant might help the consultee to understand the feelings which the patient may have about her pregnancy; the social pressures of family and community attitudes; the effect of these factors upon her ability to use prenatal care and to plan realistically for her baby. This could involve the use of didactic information about experience with unmarried pregnant women as well as consideration of the circumstances of the individual case.

The social work consultant might suggest some techniques for the consultee to use in assisting the patient to feel comfortable in accepting the consultee's help in relation to health services. Often he must make suggestions on how the consultee can assist the patient to see the desirability of using social casework service in relation to her own needs and those of the baby. In such cases social work consultants frequently need to help consultees with their own attitudes about adoption, to give information about the policies and procedures of adoption agencies and to explain adoption laws.

The unmarried pregnant woman is an example in which social pathology and the need for referral for direct social casework service is usually present. Other examples could be used in which social pathology is not present and consultation about referral for direct social casework help unnecessary. In a program which aims to prevent the development of pathological situations, the social work consultant may help the consultee to recognize social situations which might lead to physical, mental or social pathology and to deal with these before they require therapeutic services. The consultee might for example be helped to give services to school-age children in such a way as to prevent the development of psychosocial problems.

Program consultation

In program consultation, the social work focus on psychosocial factors related to health and disease is broadened to include these

factors in communities or in groups within the community. Without losing sight of the psychosocial factors which affect individuals and families, the social work consultant gives help in analyzing the health and related needs of the community and in developing or improving services to meet them.

Having used consultation about service to an unmarried pregnant woman as our example of case consultation, we can take health services for all the unmarried pregnant women in a community as an example of program consultation. Suppose that a health department found statistically that unmarried mothers had more premature babies than married women in the community. This health department might ask a consultant for help in defining the problems and developing services to meet the needs discovered. In giving this help, the social work consultant might suggest a survey of the admission policies of hospitals and clinics with special reference to the availability of prenatal and obstetrical care to this group of patients. He could point out that residence requirements should receive particular attention since many unmarried mothers seek care away from their own communities. He might suggest attention to rules which require notification of parents and filing of paternity actions since these rules are often deterrents. The social work consultant could suggest other policies and procedures which should be studied to determine what use this group can make of health services. He would point out the need to look for policies and procedures which result in failure to observe confidentiality and the existence of unrealistic attitudes on the part of staff members in hospitals and clinics.

The social work consultant might also suggest that the help of hospital social service departments and social agencies be enlisted to obtain further information on the experience of unmarried mothers in trying to obtain medical care under acceptable circumstances. In suggesting cooperation with social agencies, the program consultant might help to dissipate a stereotype about social agencies which would help the health agency to work more effectively with them in the future.

The social work consultant might go on to help with plans to set up a program for more adequate care of unmarried pregnant women. This could involve such matters as helping the consultee to plan for his own consultation service to clinics and hospitals, discussing possible methods of working with social agencies, and suggesting revisions of standards or laws related to licensure of hospitals and maternity homes. It might also involve help in planning to set up services to provide prenatal and obstetrical care for unmarried mothers. This consultation would be directed toward

prevention of problems such as maternal and infant mortality, morbidity and prematurity through provision of more adequate health services. By helping the consultee to participate more effectively in community efforts to change attitudes and to provide adequate social and psychiatric services for all young people with emotional or social problems, the consultant might make a real contribution to primary prevention.

Administrative planning is a prerequisite to successful consultation. The framework in which consultation will take place involves administrative decisions as to the purpose of consultation, the general area of content, and the channels and methods of communication which are to be used in requesting and reporting on consultation. Since consultation takes place outside the line authority of the health department, the consultant's role must be clearly understood as differentiated from and as related to the roles of those staff members who have administrative responsibility for the professional work of the consultees. This understanding must include all of those staff members who have administrative or supervisory responsibility for the performance of individual consultees or for direction of special programs or special services in which individual consultees function. Delineation of functions and the methods which will be used to assure an integrated approach when several consultants are expected to give help to one group of consultees is also needed.

When two agencies are involved—one to provide and one to receive consultation—agreements are reached at the top administrative levels. In effect, this establishes a framework in which the one agency is really the consultant and the other agency the consultee. Individual consultants and consultees may change but the basic relationship between the two agencies continues until it is terminated or changed by the top administrative authorities. Individual consultants, therefore, act as representatives for their own agencies. They act only in accordance with the responsibilities and limitations set up by the administrative agreement between the two agencies.

When consultation is set up within one agency, the same kind of planning must take place under the leadership of the administrator. The consultant functions in accordance with agreements understood and accepted by persons with supervisory authority over individual consultees.

Agreements about consultation services between or within public health agencies are usually discussed and then put in written form before consultation begins. When the consultant is to function in a different way, the changes should be incorporated into the written material. The writing of such material helps to assure an

understanding of the role of the consultant at the top levels of administration. Before consultation can proceed successfully, the role of the consultant must be made known to all of the staff members who may be involved directly or indirectly. The administrator is responsible for seeing that his staff is informed of the plan which has been developed for the use of the consultant. It is particularly important that all staff members who have supervisory responsibility over individual consultees understand and are willing to accept the role of the consultant and the methods by which he is to work. The administrator should involve supervisory personnel in the planning before final decisions are made in order to assure that the consultation planned fits in with the needs and patterns of work of particular groups within the consultee agency.

Administrative planning should include consideration of the general area of content. This must be considered first in relation to the areas in which help is desired by the consultee. If the area is confined to case consultation, the social work consultant can draw upon his education and his experience in social casework to provide the necessary content about psycho-social factors which are related to health and disease. The social work consultant who gives program consultation must know more about the philosophy and practice of public health, the organization and administration of social services, medical care and the broad field of social welfare in order to bring the necessary content. This detailed knowledge about a wide range of broad subject matter is necessary in all program consultation. Specialized knowledge will be needed when consultation is requested in regard to specialized programs, such as the development of services for a particular diagnostic category.

When a public health agency sets up a position for a social work consultant, qualifications should be set up which will assure a consultant with the knowledge and experience needed to provide the content expected. This same principle applies to the selection and use of consultation services from one agency to another. Unless these areas of special competence are respected by both consultee and consultant, there can be no authority of knowledge in the consultation.

The area in which the consultant can give content which will be helpful must also be considered in relation to the knowledge and competence of groups and individuals who are to receive consultation. The content of consultation to professional social workers, for example, may need to be different from the specialized content given to other professional disciplines. The content expected in consultation to professional social workers will differ, too, in accordance with their backgrounds. Specialized content needed by social work con-

sultees in a health agency might be quite different from the content for social work consultees in other community agencies.

Specifically in relation to the responsibilities of the consultant in this connection, the request for help is related to specialized areas about which he does not have and cannot obtain more knowledge than the consultee. This should be faced and the consultee referred to someone who can supply the knowledge that is needed. This will prove to be more helpful to the consultee, more comfortable for the consultant, and better in the long run for the maintenance of the consultative relationship.

One of the most important points for consideration in planning is the question of communication. Here we are referring to the methods which will be used to keep administration informed, rather than the techniques used in interviews with consultees.

Many of us are familiar with the arrangement that requires that consultants in Federal agencies address all correspondence to the directors of the State health department. This arrangement was made at the request of the State and Territorial Health Officers and was intended to assure that the Federal consultant's activities in relation to the State health department would be known to and would have the sanction of the State health officer. Similar plans have been set up in State-local relationships.

Many of us are also familiar with the practice of having the consultant from the outside agency talk with the health officer at the beginning and end of each visit to the agency.

In interagency consultation, requests for help are often channeled upward through various levels of supervisory authority until they reach the health officer who transmits them to the consultant. When requests are made verbally they are confirmed in writing by the consultee, the consultant, or both. In intraagency consultation, more informal methods of communication are used but it is still necessary to make sure that the activities of the consultant are known to those who have authority over consultees.

While planned communication is important to assure that consultation is sanctioned by health officers and other supervisory personnel, it is equally important as a means of implementing recommendations. Obviously it is futile for the consultant and frustrating for the consultee if recommendations are made which cannot be carried out within the existing policies and procedures of the agency. Staff members who are in a position to change policies and procedures must be kept informed of the need to make changes to permit implementation of recommendations.

Various devices have been developed to inform supervisors and administrators of the content of consultation. Unless the supervisor

is actually present during the consultative interview, the information he receives is usually a very summarized version. Any major recommendations which the consultant makes explicitly with regard to action which may be taken by the consultee should be explained to the supervisor. This may be done orally or in writing according to the procedures used in different agencies. A very desirable method is to arrange for a discussion that includes the consultant, the consultee, and the supervisor and administrator. Major findings and recommendations should be recorded.

Another question which deserves consideration when methods of consultation are being set up is the problem of deciding whether or not the supervisor will be present when consultation is given to individual staff members.

Given a clear administrative arrangement, adequate channels for communication, and supervisory support, social work consultants can give help to individual consultees with or without the presence of the supervisor. There are, however, several factors which may be taken into consideration in setting up the method from this standpoint.

A plan which interferes with the freedom of supervisors to be present at consultative interviews with staff members whom they supervise requires supervisory personnel with great security if the consultant is to avoid the possibility of intrusion or the appearance of intrusion on supervisory responsibilities.

The one to one relationship is known to be most effective in bringing about transference between a therapist and a patient. It is also the method used in supervision. The consultant who uses this method must recognize its potentialities and be especially careful to avoid involvement in the consultee's personal problems.

In planning for consultation to members of other disciplines, particularly when social work consultation is first initiated in an agency, the advantages of the one to one relationship are usually outweighed by the positive factors in having the consultee's technical supervisor present. The supervisor may be helped in his understanding of psycho-social factors. He will be able to help the consultant to understand the professional frame of reference of the consultees and to help the consultees in applying the content of the consultation to their own professional practice as carried out in the particular setting. After consultation services have been well established with the same group of consultees, the presence of supervisors on a regular basis is often considered unnecessary.

In public health agencies, as in social agencies, the presence of the technical supervisor when consultation is being given to inexperienced staff members of another discipline is considered desirable. The

basic principle here is related more to professional education than to line authority of the consultee agency.

In giving consultation to members of the same discipline, social workers in this instance, the consultant does not have to worry about the application which would be made of ideas in another professional discipline. The presence of the supervisor may, however, be desirable when consultation is given to social workers who may need the supervisor's help in applying the content within the setting of the particular consultee agency. Special care is needed in avoiding the supervisory role when consultation is being given to social workers who have no technical supervision within their own agency.

When arrangements for consultation have been made and a consultant is appointed, either the first consultant or a replacement for a previous one, consultees are provided with information about the background, education, and experience of the consultant. Usually in public health agencies this information is also made available to all staff members. Providing this information is the first step toward the development of professional relationship between consultant and consultee. To the consultee it is especially helpful in judging the areas of specialized help the consultant may be expected to bring as a result of his education and experience.

Public health agencies usually provide a period of orientation for a new consultant. During this period he is given information about or provided with opportunities to observe services rendered by the consultee group. He is introduced to individual staff members and may be informed of the professional background of individuals to whom he may be asked to give consultation. The period of orientation usually gives the consultee an opportunity to tell the consultant something about his work. The consultee sometimes tests the consultant's knowledge and interest by mentioning some of the problems with which he is faced. This period in which the consultee is placed in the position of helping the consultant to acquire information about his setting may be helpful as an ego-supportive measure at the beginning of the consultation relationship. It may also help to establish a frame of reference in which it is understood that the consultant cannot be expected to give specific answers to questions related to action in situations about which he can never have the same current information as the consultee.

The consultant's orientation should take place before he is presented with a major problem.

Sometimes serious problems arise and the consultant must respond to a request for help before he has been oriented to the consultee or to the consultee agency. Under such circumstances it is possible for him to give help to some consultees with certain kinds of problems. These

are usually situations in which the consultee can discuss the problem without a long period of testing the consultant's knowledge and ability to help or those in which the consultee is able to give the consultant sufficient information to enable him to understand the factors which must be considered in determining the nature of the problem. Obviously this is more likely to be possible when consultation is given to help the consultee to understand a problem involving a single case. When the consultee's problem is related primarily to his relationship with his colleagues or supervisors it is more difficult. In program consultation there are many problems with which consultants cannot help consultees without more knowledge than is possible to obtain in a first interview or a first visit.

When a request for consultation is made before a new consultant has been oriented to the consultee agency, sometimes the consultant can express his concern but suggest that discussion of a problem which is not urgent be postponed until the consultant has had this orientation to the agency. Sometimes, it is better for the consultant to offer to discuss the problem and to try to give help as he can *within the limits* of his lack of familiarity with the consultee's setting. This is a matter of judgment. Frequently his interest and his willingness to discuss the problem will be of some help to the consultee in working toward a solution. This willingness to discuss the problem may also be helpful in establishing a positive consultation relationship for the future. It could, on the other hand, damage the future consultation relationship if the consultant should allow himself to get into areas which require more knowledge of the consultee's situation than he actually has.

When a consultant receives a request for consultation he must first decide whether it seems consistent with his areas of responsibility and special competence. In program consultation requests are often received for help with problems which involve basic difficulties of the agency or cut across interdisciplinary lines so that the help of the social work consultant alone could not be effective. In such instances program consultants in agencies providing consultation by a variety of consultants often suggest the desirability of team consultation. The usual manner of handling requests which seem inappropriate is to express concern about the problem but to explain why the request cannot be met. This should be accompanied by suggestions as to appropriate sources of help. Sometimes the appropriateness or inappropriateness of the request cannot be determined without further clarification.

When a consultant has accepted a request for consultation his first responsibility in the consultation process is to explore the problem. This is necessary in order to help the consultant understand

the problem and to lay the groundwork for mutual understanding of the help which the consultee wants.

The consultant's role obviously calls for delicacy in exploring the problem. The consultant must be careful not to press for information which the consultee does not have. The consultee may have done as good a job as possible for someone in his stage of professional development or have obtained all the facts appropriate for someone in his particular discipline. Yet he may not have obtained all the data which the consultant might consider relevant to the problem. Pressure on the consultee may result in feelings of inadequacy on his part that is contrary to the ego-supportive techniques which should be used to help him do a more effective job.

No matter how much the consultant may feel he needs to have all the material to understand the problem, he must not press for facts or feelings which the consultee may have but is reluctant or unable to share. Reluctance on the part of the consultee to share certain facts and feelings may be symptomatic of conscious or unconscious defenses which the consultee wants or needs to maintain. Until the consultee is ready to talk about these areas, the consultant should be sure that he is not threatened or made to feel guilty about his failure to share information. Limiting help to areas with which the consultee is ready to use it is a basic tenet of the consultation process.

After the initial exploration, the consultant must arrive at a diagnostic evaluation and develop a plan to try to give the consultee the help he wants. It will be necessary for the consultant to begin by trying to determine the nature of the problem. This may be exactly the same as the problem stated in the request for consultation. In some instances, the consultant's more objective view may result in a picture which differs to some extent from the problem as seen by the consultee. These differences are more likely to appear when the consultee is at least aware of his own involvement in the problem. Sometimes exploration will have given the consultee an opportunity to express a need for help with a different problem which he preferred not to raise or which did not exist when the original request was made. Differences may also be seen when program consultation is given to individual staff members who see only one segment of a problem which affects many other aspects of an agency's program.

In making the diagnostic evaluation of the problem, the consultant must always take into account gaps in information and the possibility of bias on the part of his informants. He will need to decide what he thinks the real problem is, but at the same time remain alert to the possibility that he may have to change his mind about the nature of the problem as further facts and impressions emerge in the course of consultation.

An essential part of the consultant's diagnostic evaluation is consideration of the help which the consultee wants from the consultant. The request as stated by the consultee may express the real nature and extent of the help wanted. We are all aware, however, that conscious or unconscious factors frequently influence requests for consultation. Under the guise of asking for consultation, consultees sometimes seek to transfer responsibility for actions which they should take themselves. Occasionally consultees may have reservations which they do not recognize or cannot put into words about the extent to which they really want help to examine problems. These are only examples of the many possible motives which need to be considered.

It is particularly important to consider the nature and extent of the help desired when the problem the consultant sees differs from the problem seen by the consultee. An additional complication will arise for the consultant when it is necessary for him to evaluate a consultee's desire for help with problems which are perceived differently by an individual and by his supervisor or administrator. This is likely to be particularly difficult when the request for consultation has been initiated by the supervisor or administrator.

Having completed the initial diagnostic evaluation, the consultant needs to plan and carry out the consultation.

Social workers in public health are fortunate in having a background of education and experience which includes understanding of the principles and techniques of social casework. We have learned how to select and apply these techniques to establish the kind of relationship needed in helping patients and families to solve their psycho-social problems. From a large number of techniques available, we have learned to choose those which seem best suited to bring about the desired results with particular patients. Applying this knowledge to consultation through the same kind of study of the purpose and the results which we want to achieve should not be too difficult. The overall purpose of the consultation is different in that it is set up to deal with professional rather than personal problems. There is, however, the same need to take into account the results the consultant wishes to achieve in particular situations.

It would be quite impossible to present here all the principles and techniques that the social worker might consider in giving consultation. To do this we would have to review the principles of social casework and to show how these could be applied in the context of consultation. It would be necessary for us to go back to such basic principles as the need to start where the patient is. We would have to review material which social work has derived from psychiatry for use in understanding the meaning of behavior. This would

involve consideration of such matters as the recognition and management of transference and counter-transference in the consultation situation. Since consultation is often planned and carried out jointly by more than one consultant, the principles and techniques which we use in working collaboratively with our colleagues in social work and other disciplines would have to be discussed. The principles and techniques which the consultant must draw upon in handling consultation to groups would have to be discussed since program consultation often calls for interviews to be carried out with several consultees at the same time.

In addition, we would need to present a detailed analysis of Dr. Caplan's material, translating some of his terminology into words which the social work profession has traditionally used to describe the same techniques. And we would have to point out the applicability of each of these techniques to the handling of consultation interviews by social work consultants in public health. We would, for example, point out that social workers commonly use the word "individualization" when referring to the technique which Dr. Caplan speaks of as "dissipation of the stereotype." This is a technique which social workers have drawn from casework for application to consultation. It is an extremely important technique in consultation for the reasons Dr. Caplan discussed in his presentation.

Perhaps now we should mention some specific factors that the consultant must consider in handling the termination of a particular interview or visit. The extent to which it is desirable for the consultant to review with the consultee the content of the consultation is largely a matter of professional judgment. Obviously help which has been given to the consultee in understanding his feelings and attitudes may not be suitable for explicit review like informational material and help in considering possible courses of action. Some discussion of the help the consultee wanted and the help the consultant has tried to give may be useful to the consultee in deciding what he wants to do about the problem and in maintaining understanding of respective roles of the consultant and consultee. Judicious use of this device might, in some instances, result in more careful planning of consultation requests and be of some help in evaluating consultation service. In order to assure mutual understanding, reviewing any explicit recommendations which the consultant may have made regarding action to be taken by the consultee is always desirable. It is, of course, extremely important that the consultant be aware of and be able to handle his own feelings about the consultee's acceptance of his recommendations.

Now, to return to the administrative plan for consultation service, some plans require sharing of recommendations with the consultee's

supervisor or the administrator of the program and many consultees request that this be done where it is not required. The recommendations made should be reviewed with the individual consultee before sharing them with his supervisor. Sharing recommendations with a superior can often be done most effectively by the consultee and the consultant together.

The desire of the consultee for further help from the consultant will depend upon his feelings about the consultation he has received. If continuity in consultation is expected, as it usually is in public health programs, it is important that the consultant convey his interest and willingness to try to help with future problems.

There are several areas which deserve special mention at this point, specifically to expand our discussion of functions which may be carried out in conjunction with consultation, to give some views on recording of consultation, and to present a few ideas about the applicability of crisis to the job of the social work consultant in public health.

In our previous discussion, we omitted mention of some functions which could be considered quite appropriate as a part of the total job of the consultant though they involve the use of processes which are different from consultation; for example, the social work consultant who comes into an agency where there has been no prior experience with social work. Often it is considered desirable, and is quite appropriate, for him to give some direct casework service to demonstrate the help which can be given through social casework. Obviously, his work with other staff members on the particular cases selected for this demonstration will become collaboration rather than consultation. Similarly a program consultant might participate with staff members of a consultee agency in meeting with other community agencies in order to demonstrate the role of the social work consultant. Direct participation in in-service education may also be seen as an important part of the total job of a consultant to an agency or a group within an agency.

Careful administrative planning and constant reinterpretation of the plan is necessary to avoid confusion when the social worker is expected to divide his time between consultation and direct casework service. Without careful planning and constant focus on the problem of helping the consultee to do a more effective job himself, it is easy for the consultant to be maneuvered into the position of taking over all of the cases with social difficulties. Some consultees may then begin to seek consultation only as a means of turning over responsibility to the consultant. Other consultees may avoid consultation because they fear that the consultant will, in effect, take the case away from them.

It is possible for a social worker to take over direct responsibility for casework service as a result of a consultation interview or a referral based upon a consultation interview. This occurs primarily in intraagency and interdisciplinary consultation. It is a pitfall which could well be examined more thoroughly in order to analyze the factors operating and to aim at better methods to avoid the problems which arise.

Recording

Unfortunately the content and process of consultation is seldom recorded in detail. The preparation of detailed records in consultation, as in casework, is valuable for the professional development of the social worker. Social work supervisors in public health programs would find some detailed records most helpful, especially when they are assisting staff consultants to learn the process of consultation. The scarcity of such records is a real handicap in analyzing and teaching the content and process of consultation.

Obviously recording of the content and process of consultation as a routine procedure in all instances would be unrealistic except when done for purposes of research or teaching.

But some record of every instance of consultation is desirable. It is particularly important to record any major recommendations with at least a brief statement as to the reasons why they were made.

In case consultation, this recording might be done by preparation of summary or note for the patient's record. Sometimes recording can be done by the consultant and the consultee at the close of the consultation interview.

In program consultation, the field report and the letter that confirms discussions taking place during the consultation are the two devices most frequently used for recording. The field report is usually prepared for use by the agency in which the consultant is employed. It usually contains major observations, recommendations with an explanation of the reasons for them, names of individuals to whom consultation was given, and any future plans for consultation. These reports serve as a means of communication within the consultant agency and promote integration of service when several different consultants are giving consultation to the same agency. They provide valuable background material for new consultants coming into agencies with an on-going consultation service. Field reports are also useful for staff members in consultant agencies who are responsible for supervision or direction of the individual consultant's work.

It is impossible to generalize very much about the confirming letter or report which may be sent to the consultee agency except to say that this is usually a desirable practice in program consultation.

These letters and reports are developed to meet the needs of different agencies at different times. The content to be covered is based upon prior discussion between consultant and consultee.

Crisis-Oriented Consultation

Many questions have been raised about the application of the material Dr. Caplan presents on crisis-oriented consultation. In his presentation Dr. Caplan points out that the principles and techniques he describes were developed to accomplish the purpose of a particular kind of agency. He suggests that these might be applicable to other situations but he warns against taking bits and pieces for general application. By examining the purposes of our consultation, we can determine when to apply or not to apply any or all of these techniques. If, for example, the purpose of the consultation is to give help about the development of a new service in an agency, an experienced social work consultant in public health would not choose a time of crisis. Consultation on this kind of problem usually involves giving specialized information, sharing experience, reviewing principles, attempting to broaden the professional perspective of the consultee, and making suggestions about possible courses of action. It is usually easier for the consultee to focus his attention on this kind of material when he is not in a state of disequilibrium. This noncrisis type of consultation, however, utilizes many of the same techniques recommended by Dr. Caplan for use in crisis-oriented consultation.

If the purpose of our consultation is to help consultees to solve problems in which feelings and attitudes are of primary importance, the techniques most frequently chosen may be different. Some will be the same.

In public health, consultants usually prefer to be asked for help in identifying and dealing with problems before they lead to crises. It is not always possible to foresee problems or to give help which will prevent crises from arising. We know that there are some situations in which a crisis will have to develop before consultation will be effective. We frequently recognize this in situations where consultees repeatedly ask for help without taking action to solve their problems. If the consultant is reasonably sure that he has tried to give all the help he can with a chronic problem like this, he may deliberately try to avoid discussion of the problem in order to await the time when the consultee feels an acute need for help.

We see this, too, in situations where consultants are aware of the existence or possible existence of problems which have been touched upon peripherally but never brought up explicitly by the consultee. Through exploration of relation problems, the consultant is convinced

that the consultee is aware of these problems but is blocked in his ability to request help. In such cases social work consultants usually try to make themselves available to help with nonthreatening problems, meanwhile trying to avoid discussion of matters too closely related to the undisclosed problems. The consultant may consciously await development of a crisis with the thought that disequilibrium will enable the consultee to use help more effectively.

Social work consultants in public health programs often find themselves in the position of consultees. The field of public health is complex and may change rapidly in accordance with new knowledge developed by many different disciplines in a number of allied fields. In order to keep up with new trends in public health and the development of knowledge about psycho-social factors and social services related to health, inevitably social work consultants in public health find it necessary to seek expert advice in order to maintain the authority of knowledge required for consultation. Perhaps we might gain some additional understanding of the consultative process if we looked at it from the standpoint of our own responsibilities and reactions when we request or receive consultation for ourselves.

PROGRAM CONSULTATION

VIRGINIA INSLEY

Chief, Medical Social Work Section

Division of Health Services

Children's Bureau

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PROGRAM CONSULTATION

This discussion will be focused on the role of the medical social worker in program consultation. Although the same principles and many of the same methods of consultation would be applicable to any agency, the frame of reference in the presentation is the health agencies. Those of you who are concerned with consultation to other kinds of agencies will determine the pertinence of this discussion to your own situation.

Consultation is a helping process which involves the use of professional knowledge and professional relationships between one or more professional people. It takes place within the framework of an administrative arrangement which sets up channels of communication between one person or agency and another person or agency. Where an agency is involved in providing or receiving consultation, the arrangement is officially recognized by the administrative authority in the agency. Responsibility for carrying out the recommendations of the consultant rests with the consultee even though the consultant may assist the consultee to carry out certain suggestions upon request. Consultation is given in response to a request for help which may be the expression of a need by an individual or a group of individuals.

Case consultation is usually sought because the consultee feels he needs assistance in helping his patient to solve some kind of problem. Program consultation may be sought because of a problem or problems which impede the carrying out of program objectives. Program consultation is also sought when an agency is considering or planning to start a new program. Consultation may be requested too, when an agency wishes outside professional help in its evaluation of a program or particular aspects of a program. Case consultation often involves consideration of policies and procedures of a program as they affect a particular patient or family. Program consultation is directly concerned with these broader aspects as they affect the service to all patients.

Direction and supervision obviously differ from consultation in that consultation does not and cannot carry with it administrative authority over the consultee. Consultation also differs from collaboration between two professional workers serving the same

patient in which both carry responsibility for direct service to a patient. Similarly, the help which a medical social worker gives in relation to program planning within his own agency is usually collaboration rather than consultation. Consultation as a process differs from teaching although there are educational aspects to consultation, particularly to that consultation which deals with content of programs.

Program consultation is directed toward helping an agency to set up or to improve services in line with the needs of the community and the goals of the agency. It requires understanding of the resources of the particular community and sensitivity to the stage of development of the program. In principle it is the same as case consultation, which aims to improve the care of the individual patient and to strengthen the consultee, to analyze situations, to solve problems and to plan for the future course in developing and administering programs and services within programs. For the medical social consultant this means helping the consultee to identify medical social factors—needs and services—and to plan to meet these needs as effectively as possible.

Program consultation as given by medical social consultants is directed toward improvement of program from a medical social standpoint. When medical social services exist within a program, this consultation is focused primarily upon the strengthening of these services. Whether or not consultation is focused on medical social services it always involves consideration of the medical social factors in the total program. To be effective it must also involve knowledge and consideration of the goals and needs of the whole program.

The consultee in program consultation may be an agency or a unit within an agency which is, however, made up of individual professional people. One individual may be the primary consultee within the program with whom the consultant works most directly. This individual may or may not be the person who is responsible for the program and for initiation of the request for consultation. When there is a medical social worker in the program, the medical social consultant frequently and rightly devotes much of his time in the agency to direct consultation with him or team consultation in which he is included.

The program director and the medical social worker, if there is one in the program, are usually the two individuals to whom medical social consultation is given most directly. The consultant's handling of relationships between himself and these two sometimes poses delicate problems since the consultant has responsibility for helping both as individual workers toward a solution of the problems

which either one or both feel are affecting the program as a whole. The relationship between these two professional people, the other professional disciplines in the program, and even higher authorities in the agency, pose additional problems of reaching objectives for particular programs and disciplines in accordance with the goals of the total agency. In other words, often several different individuals of different professional disciplines on different administrative levels and with varying degrees of authority in their relationship to each other make up the consultee unit. The consultants' recognition of their relationships—personal and professional—to each other is as important as is his recognition of his own relationship to each of them.

The consultant is responsible for helping the consultee (agency or worker) to define the situation or problem for which consultation is sought, for suggesting and helping the consultee to supply information needed to understand the situation, to help the consultee to analyze the situation, and to arrive together at the final recommendations. The consultant's sensitivity to how far the consultee can and does wish to participate determines how extensively he uses these methods or whether they are used at all.

The consultant who represents another agency can and frequently does carry additional responsibilities in his own agency which create a professional relationship that is different and apart from the consultation relationship. For example, when money is granted to the consultee agency by the agency in which the consultant is employed, this may involve the consultant's being cognizant of the consultee's adherence to certain regulations and encouraging the consultee to carry out programs in accordance with these regulations. He will also be responsible for reporting to his own agency on the conformance of the consultee agency with respect to these regulations. It is important for the consultant to realize that occasionally the consultee imputes supervisory responsibility in such situations. Therefore, these additional responsibilities must be clearly defined and understood by both consultant and consultee.

Inevitably any program consultant attached to an agency with responsibility for stimulating extension and improvement of certain kinds of services, or an independent consultant with specialized knowledge in a particular field, has some motivation to bring about certain changes in a program to which consultation is given. It is just as important that any special interests of the consultant, whether motivated by agency responsibility or by professional interest in program development, should be recognized so that the respective goals of the consultee and the consultant can be kept clear.

Frequently the consultant or someone in the agency with which he is associated has played a part in stimulating the request for consultation because the consultant agency feels, or may legally have, some responsibility for improvement of the program of the consultee agency. If we are convinced about the importance of medical social factors in programs, if we can be clear as to the effect which stimulation of requests for consultation may have on the process of consultation, then we can feel comfortable in meeting the requests for consultation which result from these activities.

Some reason for a consultation request is always stated. Sometimes this expresses a real need for help in starting a program or meeting problems in an existing program. Occasionally what is described as a need for consultation is primarily a request based upon a pattern of consultation from a particular agency. Sometimes the real need is obscured by a statement which reflects what the consultee or his agency considers a socially acceptable reason to ask for consultation. There are few, if any, requests for consultation which do not really contain the elements of a need for help.

Questions are often raised about consultation which is imposed on the consultee. Obviously this could only be as the result of some action by a person having an administrative or supervisory relationship to the consultee which the consultant cannot have. This kind of situation may arise when a health officer requests consultation in relation to programs or activities in which direct responsibility is delegated to other personnel. Such situations are not entirely new to medical social workers. They resemble the case situation in which someone else on the medical team refers a patient who does not understand why he is believed to need the help of a social worker. We have handled these situations in casework and can certainly handle them in consultation.

When a consultant is coming into the situation for the first time without any personal relationships with the consultee and without having demonstrated his competence, requests tend to be general or, if specific, to be more superficial than the requests which come later during his visit or in preparation for future visits. This is particularly true of consultation which is requested of medical social consultants by agencies with little or no experience with medical social work. Though it is desirable for an agency to be clear as to the general reasons why medical social consultation is desired, it would be unrealistic and sometimes detrimental to establishing a helpful relationship if we insisted on the agency's being too specific in its first request for help. Many times agencies are not clear about the extent and nature of their problems and count on the consultant to help them identify as well as solve such problems.

The consultant begins to explore the situation as he establishes his relationship, taking up the problem as stated by the consultee and carrying on throughout the consultation process. If the consultation is effective, the consultee should become better able to state the problems with which help is requested. These problems are then considered as they are clarified and the recommendations made by the consultant can be related to the problems brought out. The time to expect more specificity in requests for consultation is an individual matter but would seem to be a goal to be worked toward increasingly as consultation progresses. In continuing consultation, however, some value may be lost if discussions are allowed to go on too long without focusing sufficiently on problems or situations with which the consultee sees the need for help.

In program consultation as in case consultation the consultant must avoid being drawn into a supervisory role by his own needs or those of the consultee—either of an individual consultee or of someone in the consultee agency with authority over the individual consultee.

While it is often valuable from a diagnostic standpoint for the consultant to see what roles the consultee may try to ascribe to him, he must be conscious of the role he is actually playing. He should be particularly careful of the part his own needs may play in being placed in the role of expert and should bear in mind that he seldom knows as much about the local situation as the consultee does and that he will not be present to carry out the suggestions he makes. Of course the consultant should not negate the value of the knowledge which he has. He should be comfortable in the role of expert in giving the information he really has, acknowledging his lack of experience when he does not have the requisite knowledge and keeping in mind that programs, like patients, have individual needs to be understood and dealt with on an individual basis. When asked how to provide some service or to handle some problem, consultants frequently describe the methods used to deal with similar situations in a number of different ways in other programs. Thus the consultee can benefit by the experience of others and have an opportunity to develop a plan that fits the needs of his own situation.

Direct handling of personal problems is not a function of the consultant. Just as we recognize in case consultation that the personality and the attitudes of the consultee affect his ability to deal with the patient, so we must recognize in program consultation that the personalities and attitudes of the consultees affect their ability to work together within the agency, to relate to the community, to plan and to carry out programs effectively. We recognize

the personal problems of the consultee in case consultation and have found that we deal with them most satisfactorily through discussion of the patient and his situation. We deal with the personal problems of the consultee in program consultation primarily by helping him to discuss his problems in terms of understanding and solving problems of the program.

In addition to conferences with consultees some of the methods which a medical social consultant uses to understand the program of the consultee agency and to discuss its problems include review of records, reports and statistics, conferences with key persons in the agency and the community, and observations of services and other activities—all of these, of course, contingent upon the consultee's willingness to share these facts and experiences with the consultant. In this connection we have to mention case consultation as one of the methods that can often be used effectively in relation to program consultation in those situations where a medical social worker is not available in the program to which consultation is given. Such service when given in appropriate situations can serve several useful purposes. It can be a real help in understanding the problems of patients served by the agency; often it leads to a better understanding of the effects of policies and procedures set up by the agency, reveals information as to gaps in services in the agency or in the community and suggests areas in which further understanding of social and emotional factors could be provided through staff education. Case consultation in an agency that does not have a medical social worker on its staff can often be an important factor in establishing a relationship which carries over into program areas and is frequently the best means of demonstrating the role and value of medical social service to the consultee agency. By participation in in-service education programs the medical social consultant can also build relationships and demonstrate the contribution of medical social service. It is important for the program consultant to participate in such activities only so long as it is really impractical for the consultee agency to employ its own medical social worker.

If we believe that a health program planned by representatives of all the professions involved benefits not only from the contribution of each discipline but from new ideas which may grow out of the pooled thinking of all disciplines, the value of team consultation seems obvious.

Program consultation has always had team aspects and interest in the special values and problems inherent in consultation by teams of different professional disciplines. Consultation by a team may take place through conferences of one or more consultants with one

or more consultees. Frequently a mixture of individual and group conferences is involved. In whatever form the process takes place, all of the principles which hold true for consultation to one individual apply. In addition certain values and certain skills are particularly applicable to team consultation.

The effectiveness of team consultation depends upon the ability of each member of the team to understand and accept the functions and philosophies of the other team members. The team must be able to plan and carry out consultation as a coordinated unit. The medical social consultant is responsible for helping other team members to understand medical social work and to use their help in understanding the disciplines which they represent. The medical social consultant carries primary responsibility regarding social aspects and social services both in planning and carrying out team consultation. He has the responsibility for assuring that this content is brought out wherever it is appropriate. Other members of the team carry responsibility for interpretation of these aspects and services under certain circumstances, just as the medical social consultant must draw on the knowledge gained from other members of the team to help interpret the point of view of the other disciplines and draw them into situations where appropriate. The primary responsibility of each member for contribution in his own field and the shared responsibility for contribution in the other fields is illustrated by the situation in which the medical social consultant meeting alone with medical social work staff of a program is able to use his knowledge of other fields to recognize and to help the medical social consultees to see the contribution of another discipline. In team consultation this often leads to subsequent sharing of the discussion on an interdisciplinary consultation basis.

Team consultation is valuable when a new program is being set up or an established program is being evaluated in which medical social factors or medical social services are involved along with other factors and services—in other words in every health program with which medical social workers are concerned. In such instances the members of a consultant team of different professional disciplines can help the consultee agency to make appropriate use of the skills of their professional counterparts in the consultee agency from the outset of the planning for development or evaluation. When the need for consultation arises because of problems affecting different professional disciplines, consultation by a team with representation from the disciplines concerned is often the most effective way to identify and help solve problems. Frequently a problem which is believed to be peculiar to medical social work is found to be

common to other disciplines such as nursing and physical therapy; the solution may lie in the hands of still a different discipline such as the administrator of a program. Such problems are frequently handled by a team of consultants through a succession of conferences which at different times bring together the members of a single discipline in both the consultant and consultee team and at other times include interdisciplinary team conferences. Such meetings permit exploration and problem solving according to the needs and patterns of different agencies.

When a consultee agency is having difficulty in interprofessional relationships or is unable for some reason to use the skills of its various staff members to the fullest extent, consultation by an interdisciplinary team which really plans and works together may be helpful as a demonstration. The acceptance and support of each team member by the others as well as their ability to recognize and use the unique contribution of each discipline on the team, is frequently helpful in bringing about increased understanding and use of the consultant's counterparts within the agency receiving consultation. Medical social work will help and be helped in this process.

It is always important that the medical social consultant maintain his professional identity in team consultation. When a medical social worker is in the program to which consultation is given the medical social consultant should maintain a clear identification with him as well as with the team. This is particularly important where medical social service in the consultee agency is having difficulty in making its contribution to the program or in its relationships with other disciplines represented on the consultant team. The presence of a medical social consultant who has a good relationship with the other disciplines on his team can be a positive influence. It can also be a threat to the medical social worker in the program, if he does not have satisfactory team relationships. An unfavorable contrast could be made unless steps are taken to prevent it. Only if the medical social worker in the program feels a real sense of security in his relationship with the medical social consultant can this be prevented. If the goal of the medical social consultant is to assure, insofar as possible, that medical social factors will be considered and medical social services will continue to be developed after the consultation is completed, his help should be given in such a way as to strengthen medical social service in the agency. Sometimes this means the consultant's insistence where appropriate upon the presence of a medical social worker in the program at a team conference on an agency level at which he does not usually participate. It always means a conscious effort on the

part of the consultant to present his ideas in such a way that they are clearly understood as characteristic of the profession of medical social work.

When a medical social consultant alone gives program consultation to an agency in which services are provided by a team of different professions, inevitably he will meet with groups of different professional individuals in the course of gaining understanding of the program or discussing recommendations. He will obviously need to understand the interaction between the various members of the consultee group as well as his own relationship to each of them. The relationship which he has with members of other disciplines will be colored of course by the understanding they have of medical social work and perhaps even more by their relationship to medical social work staff in their own program. Group meetings in team consultation call for even more understanding and skill. Each member of the consultant team must be aware of the influence of identifications and relationships in consultant and consultee groups and between the two groups both as a group and as individuals. Consultation given by teams in group meetings calls for the highest degree of interdisciplinary understanding since advance planning by the team can provide only in a limited way for the handling of specific questions which can be predicted in advance of the conference.

The effectiveness of consultation at times of crisis is receiving a good deal of discussion currently. We are not going to dwell upon this at length since we all know that the degree of discomfort in a situation is a determinant in the motivation which an individual has in using professional help to relieve the discomfort. Because we know this fact some people may tend to feel we should try to reserve consultation for crisis situations. Perhaps in certain instances when we have enough information about a situation and the people in the situation it would be best to follow this pattern insofar as possible. Before making such a decision, however, we should be sure that we are not comparing the effectiveness of consultation in a crisis situation with the ineffectiveness of consultation that is given without sufficient reference to the needs felt by the consultee. At the extremes, consultation varies from consultation that is successful because it provides useful answers to the serious problems with which consultees need help to consultation which is not useful to the consultee because it is related to some problem which seems important only to the consultant. Between these extremes there is a wide area in which help may be given on less pressing problems that can be recognized by both consultant and consultee.

In any consultation we need to bear in mind that there are large crises and small crises and that the seriousness of a particular crisis has to be judged by the consultee's standards. In program consultation, we frequently find that the same crisis or problem is viewed differently by different members of the consultee group—by the administrator as a serious problem and by the medical social worker as a minor one or vice versa. In program consultation, often crises can be prevented from developing at all. For example consultation given in relation to a new program just being developed; the consultant can use knowledge of problems that have arisen in other programs to help the consultee profit from the mistakes of others.

Questions have been raised too, about the comparative value of "one shot" consultation as opposed to consultation on a continuing basis. Here, the principal point for consultants to bear in mind is the extent to which situations can be understood in a limited period of time and the necessity to confine the information or suggestions to the help which the consultee wants and can use at a given time. An important factor in continuing consultation is the consultant's ability to relate it to the real needs of the consultee. By this we do not mean that the consultant is rigid about demanding certain statements of the need for consultation, or that he does not offer help, or make exploratory visits but only that he be clear about the reasons for his consultation.

We have heard a good deal about the culture of institutions which is a very important factor to be taken into consideration by the medical social consultant. Understanding of this culture is implicit in much of the literature on consultation which points out the need to involve supervisors in consultation. What is not spelled out so clearly is the fact that program consultation given by medical social consultants can be implemented only insofar as the recommendations are acceptable to the administrative authority—usually a physician—in the program. This has implications for the conduct of consultation; specifically it means that it is usually desirable for the medical social consultant to discuss any recommendations with the director of the program as well as with the individuals to whom direct consultation is given. It also has implications which support the desirability of team consultation in which the professional counterpart of the program director participates. The support and interest of a physician on the consultant team is frequently very helpful in involving the physician who is program director in the consultation process.

As we all know some advantages are to be gained from an opportunity to talk with a professional person outside the immedi-

ate situation. To the extent that this is true, a medical social worker of reasonable competence would have something to offer as a consultant. We know much thinking has gone into development of the consultation process as a technique that involves the application of specialized knowledge through the conscious use of relationship. To be truly effective as a program consultant certain areas of knowledge, certain kinds of experience and certain skills, are desirable for a medical social worker to have. Some of these can be listed without any attempt to place them in any order of importance:

Knowledge of the principles of medical social work with experience in their application in social casework, supervision, case consultation, administration, and education (both of social work students and of other professional disciplines in the health field)—not only because he will find many of the skills involved in these functions applicable to consultation, but because a program consultant may be called upon to give help regarding these functions.

For the medical social consultant who wishes to function in relation to health agencies outside the hospital, hospital experience is desirable since consultation to hospitals and medical care programs is frequently involved and because many of the services in any health agency are related to hospital care.

Knowledge of what constitutes good health and medical care; understanding of the philosophies of health and medical care programs; understanding the structure of agencies which provide health services and of their legal bases.

Knowledge of the philosophies and functions of social agencies since the medical social consultant will carry special responsibility for interpretation of their relationships to health programs.

Considerable knowledge of education for and functions of other professional disciplines involved in giving service in the health programs.

Knowledge of cultural factors in agencies and communities and ability to apply this knowledge in carrying out consultation which takes into consideration the applicability and the acceptability of standards and methods in different situations.

Knowledge of research methods and their use in relation to analysis and evaluation of health programs.

Knowledge and skill in community organization.

Some knowledge of social group work and considerable knowledge and skill in using group process.

Interest in and ability to keep abreast of developments in social work and in the special fields of health with which he is concerned.

Ability to function as a part of an interdisciplinary teams is essential to effective program consultation. We take this for granted in all medical social work practice but it is too important to omit special reference here.

Knowledge of the dynamics of behavior is essential to all medical social work. None of the other knowledge and skills of the medical social worker would be of value in program consultation without this background.

We are making real progress in our consideration of the consultation process, particularly as applied in consultation regarding individual cases. With the expansion of new programs having strong medical social elements and the increasing recognition of medical social elements in existing programs, it is essential that medical social workers know how to give effective consultation in relation to the development and improvement of programs. Further examination of the consultation process as applied to programs is necessary to improve our current practice and essential if we are to teach medical social workers to apply the process effectively.

APPENDIX

Papers on Public Health Mental Health

THE ROLE OF THE SOCIAL WORKER IN PREVENTIVE PSYCHIATRY FOR MOTHERS AND CHILDREN*

By Gerald Caplan

I'm going to base what I have to say upon some ideas in preventive psychiatry with which you are probably already familiar. And, upon the basis of these ideas, I'm going to think aloud about where the present day social worker may fit in.

Perhaps the most important idea which governs our thinking in this area is what you might call the ecological theory of emotional health. The evaluation of the state of health or ill health in an individual can be conceived of as an assessment of a type of internal equilibrium, a balance of intrapsychic forces in a more or less stable state. This is an intrapersonal phenomenon. Significant thinking at the present time ascribes tremendous importance to the concept that what is going on inside that individual is, in the here-and-now situation, part of a complicated interrelated field of forces which includes not only these intrapersonal forces, but also the interpersonal forces between him and the members of his relevant human environment, and between other forces in his wider social environment.

The concept is that what is going on inside any individual is in dynamic interplay and is at every moment affected by what is going on outside him. If we wish to get a clear idea of what is happening, we should not divide them.

We are beginning to realize that for too long we have carried over into the preventive field, without too much thinking about it, a basic idea from therapeutic medicine which is not too valuable here, namely, the use of the concept of "the individual patient" as our reference point. This is a useful focus if we are dealing with an illness which is associated with structural change in an individual. We can isolate this individual with more or less relevance to our investigations and to our treatments. We focus on our patient and then we think of the forces acting upon him; the forces that acted beforehand to produce the pathological effect, and the forces that may act afterwards to change him either for better or for worse.

When we are thinking in preventive terms, this can be a very misleading concept! We're beginning to realize that we should think of a field of forces, of a unit of society—whatever the size of it—rather than of an individual patient.

Another important idea is the concept of crisis, which is associated, of course, with the idea of equilibrium; because one significant thing about a balance of

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forces is that sometimes it may get unbalanced. We have discovered that a state of emotional ill health in an individual is preceded at some time or another by a significant period of disturbance of his previous equilibrium. The person passes through a period of emotional upset which is not in itself an emotional illness, but which leads eventually to a new state which may be the equilibrium of ill health rather than that of health. Moreover, this upset in the internal balance of forces in the individual is usually precipitated by and is the reaction to a disturbance in the field of forces by which he is surrounded.

In other words, we are thinking of webs of forces with the individual we happen to be looking at as part of them and reacting to them. The outcome of this crisis, which is usually not too protracted in time, will determine the type of lasting equilibrium which will emerge and whether this is a healthy or an unhealthy state.

Now, what is very important for us to realize is that during this period of crisis, when the balance of forces is unstable, when it is, as it were, "teetering", a relatively minor force acting for a relatively short time can switch the whole balance over to one side or the other—to the side of an equilibrium which is one of mental health, and if we switch it down to the other side, to one of mental ill health.

During the particular period of crisis, a few hours, a few days or at most a few weeks, a small force acting for quite a short time produces lasting changes which that force could never produce either beforehand or afterwards.

Another point is that at this moment of crisis, certain significant forces in the environment are especially important, and, of course, one of the outstanding of these forces is the relationship of certain key people to the individual concerned. This relationship may be supportive—that is, tending to weigh the balance down in a healthy direction—or it may be weakening and destructive, that is, pushing towards illness.

Even though I talk about how we have to analyze the problem in terms of webs of relationships and how we must avoid the concept of the "patient," I, too, as I begin to discuss it, immediately begin thinking about an individual and the effect of the forces on him. At the same time I realize, however, that I have to think also of other individuals in the field. For instance, we see a child who comes as the "patient" with some symptoms for treatment. We enlarge our focus and we find that he has a mother with a disturbed relationship towards him. We think that there is a causal connection. Then we do something to undo this disturbance of relationship between the mother and the child. That's fine, if we're therapeutically oriented; in which case we will say to ourselves, "Here is my patient, I must cure him." Perhaps we do cure our patient.

But many of us in the past have been rather rudely surprised to discover that if we followed up such a case and if we widened our focus just a little more, we found that maybe the father who up to the time of therapy had been reasonably well now becomes disturbed; or another child; or a grandparent. In other words, the more we narrow our focus, the less we need to take into account that our manipulations are causing change in the field as a whole. Of course, we might quite validly say, "Well, all we're interested in is this particular child"; and yet we may find, if we are honest with ourselves and if we watch the situation afterwards, that we have benefited the child, but at the expense of the mother or one of the other children. And who knows, and usually we are not in a position to know because we have closed the case, whether the final reaction, even for that child, may not be worse than the first condition?

That leads me on to the question of whether one can adequately analyze any emotional situation? And we can. The crucial question is where do we draw the circle of our investigation? We used to draw the circle around the patient, let's say, the child. At that stage all we were interested in was what was going on inside the child, in the intrapersonal difficulties of the child; and we got very proficient in working out techniques of investigation and treatment for these intrapersonal difficulties.

Then we got a bit wiser and spread the circle of our interest a bit wider, around the mother and the child. We talked about mother-child relationships and their disturbances. And nowadays I suppose in most places people are getting a bit restive and they're saying, "Well, we ought to draw the circle wider still, around the father, the mother, and the child." And when we do that, we've started on a process, and we begin to say, "We ought to take the siblings in. And maybe the grandparents."

And we begin to ask ourselves, "Well, now, what about the father's work situation, what influence does that have?" Then we realize that the child isn't always at home, he goes to school. Should we bring the teachers in? And if we bring the teachers into our study, what about the social structure and culture? And if we are going to take that into account, well then what about the tensions in the surrounding community?

Eventually all these forces from outside narrow down and impinge upon the particular child, the original patient who was presented for treatment. And so we can make our analyses in regard to the intrapersonal situation which the person presents, or we can add the interpersonal forces in the small group of the family. We can make a sociological analysis in regard to the structure of that particular community; we can analyze the situation anthropologically from the point of view of the systems of customs and values of that particular culture which sanction certain behavior of individuals in that situation and give them the support and protection of the group as a whole.

It now becomes pertinent to ask ourselves, "Where do social workers come in? What is the role of the social worker in regard to these ideas?"

A good way of beginning to think this out is to say that the role of the social worker will obviously be influenced and determined by her previous professional education and experience and by the kinds of skills which she has developed. I think it's clear from my analysis so far that she has one very obvious role, a role perhaps hardly possible to any other clinical worker; she is the specialist in assessing environmental phenomena.

The theoretical concepts that I have referred to offer the social worker new opportunities and, at the same time, a new challenge. This thinking sounds a clarion call to the social worker in this country to return to her vocation after a period of several years when I feel she has strayed from her traditional path. This she has done when she has altered her focus from the social aspects of casework to the intrapersonal aspects of psychotherapy.

Recently in talking to a visitor from Sweden, I was asked whether, in this country, social workers make home visits. I told him, "Years ago social workers in the USA did a lot of home visiting. That was when they were interested in the cruder aspects of the environment. And then they became aware, as sensitive people, of certain emotional phenomena; not just of the size of the room or the arrangement of the furniture and the number of people in the family, and so on, but of the emotional factors in the environment. And that's when they came over to start a partnership with the psychiatrists." I hope this audience will not consider me presumptuous if I say that in developing this partner-

ship they have been intellectually seduced by psychiatry and its philosophy of the moment.

Until quite recently values among social workers were such that they felt that to do ordinary case work was rather low quality work. The important thing became to deal with the intrapersonal emotional factors, to do something which was rather hard to differentiate from the kind of work which psychiatrists call psychotherapy; namely, focusing on the intrapersonal difficulties of the client, handling him in an interview situation, and working out techniques for relieving his intrapsychic conflicts. And I won't say that social workers did better or worse than the psychiatrists from the point of view of results. If I had to train someone *ab initio* as a psychotherapist, I would probably feel that a trained social worker would be a better candidate than a physician.

But I think that the time has come when social workers should realize that they have, in these newer concepts, a tremendous field of opportunity, the opportunity to make use of their traditional knowledge of environmental factors, but not in the old way—in a new way which has been leavened and changed by their increased knowledge of emotional factors and, most important, by their knowledge of the unconscious implications of overt behavior.

The theme of the unconscious implications of overt behavior is tremendously important. It is the basis of psychotherapy. But it needn't be restricted to psychotherapy, it needn't be restricted to the intrapersonal phenomena; you can make use of this knowledge and this sensitivity in regard to the environmental forces which impinge upon people.

What then are these functions which the social worker might take on in this tremendous field?

First, and this is very obvious, she is *par excellence* the member of a clinical team to advise where to draw the circle in the strategy of assessing a situation.

This is a difficult and important question because we can't draw our circle around the world. There has to be a place where the width of the circle, from the point of view of learning which forces are significant, has to be countered by the width of the circle from the point of view of being able to handle in a practical way the crucial forces. Certain factors are going to be critical, and certain are not. You can't go into history and economics, and politics, and, if you did, you wouldn't get anywhere. You might perhaps, at the end of a very long life, get an accurate analysis of a particular situation; but you wouldn't get too far, from the point of view of doing anything about it.

A clinical team needs someone who is expert in these environmental factors to say, "Where do we draw the circle? Do we take in the school in this case? Do we take in local community tensions in that case? Do we take in sub-cultural phenomena in the other case? Do we take in the father? The grandmother? Who do we take into our study?"

In order to do this, the social worker must change her habits of work. She must go back bodily into the field. Maybe some of you started off by spending your time in the field and then worked your way up to an office with a carpet on the floor. Maybe returning to work in the field may involve the danger of loss of status, as well as being less comfortable!

You can learn something about the field, no doubt, from interviewing the mother and child in your office, but you can't really learn the essential things you need to know for our present purposes. You can't learn what are the significant parts to deal with without actually penetrating the environment and getting the information by your sensitivity to the behavior of the people there. In other words, you will not get the implications of the factors which are operating in the field if you get the information distorted by the eyes and the ears

and the unconscious parataxic distortions of someone who is himself emotionally involved in the situation. Most of you have probably discovered by now that if you listen to the story of the wife about her big, hulking brute of a husband you're sometimes very surprised indeed when you meet a poor, little drippy sort of chap who wouldn't hurt a fly. It's only by actually penetrating the field that the social worker gets the relevant information.

There are techniques to be worked out in assessing the field situation. It's no longer the easy thing that it was twenty years ago, because now you're paying attention not only to the surface manifestations but, in addition, to the deeper implications of those surface manifestations. Once upon a time if you went out on a home visit and someone offered you a cup of coffee and you wanted to be nice and polite, you took it. Nowadays you have to think, "Well, what does this mean? She offers me a cup of coffee on this visit but she didn't do this last time. What does it mean that she leaves the door of the room open? What does it mean that she suddenly raises her voice while issuing the invitation? What does it mean that 'by chance' she has neighbors visiting her? What does it mean that there's someone there in the corner she doesn't introduce me to?" Those are now very complicated problems. You have also become sensitive now to what you do. What will happen if you take the coffee; what will it mean to her if you don't take it?

This problem of assessment of the relevant forces in the environment and the role of the social worker in bringing this knowledge into the clinic is linked with another role. The social worker by virtue of her skills and her education is able to make a unique contribution in regard to the tactical considerations in any case in working out and implementing a plan of preventive intervention.

She is usually the only person who can validly say how much of the work in any particular case can be done inside the clinic walls and how much has to be done in the field, because she is the only one who really knows the field.

I would now like to turn to techniques of preventive intervention which are appropriate for the social worker.

First of all there are the techniques of direct treatment of interpersonal relationships in the narrower circle; and this is an area where a certain amount of work and research has been done in recent years. Let us take, as our example of such a small unit of society, the family group, which we have now clearly recognized to be an intense field of forces that is highly significant for the mental health of each of its members. A lowering of the general morale of this group or a disturbance of the interpersonal relationships among its members will in many instances lead to emotional illness in one or another of them, and in the children to disorders of personality development.

Now, in such situations a psychotherapist can do very little from the practical preventive point of view. Why is this? Let us say that the mother's disordered relationship with her child is in this particular case dependent upon a disorder of her own personality, i. e., an intrapersonal disorder which is manifesting itself by the symptom of a disordered relationship with the child. If we try to prevent the development of neurosis in the child by taking the mother on in psychotherapy, we may succeed but the expenditure of psychotherapeutic time will be such that our service will be indistinguishable from that of a remedial clinic. I doubt whether the Community Chest gains by paying for adult psychotherapy in place of child therapy! Nor would there ever be hope of community coverage.

But we know, and this has been shown in France, in Denmark, in Israel, and in this country, that it is often possible to repair the disorder of interpersonal relationships without taking on that particular person as a psychotherapeutic

patient. You can work out techniques which will put the relationship right without becoming involved in putting the underlying personality problems right at the same time. It is possible for a woman to have a healthy mother-child relationship even if she is neurotic; and it is possible for a woman to have a disturbed mother-child relationship even if her general personality is healthy. We understand this by postulating that the relationship involves only one segment of her personality. Not all her problems are going to focus on the child. Whether her personality as a whole is neurotic or not, she may attempt to solve only certain of her problems through the child.

We can prevent her using the child to solve her problems by means of one of these "unlinking techniques." But then we have to ask ourselves, "In what way is she going to solve these problems?" I suppose one rather good solution, from the community view, is that she should solve her problems by developing some stable neurotic symptom.

I'm not really putting this forward as a practical program, but let us not forget that neurosis is a community syntonic phenomenon. Neurosis is the individual's sacrifice for the good of the community. It is not against the community's interests until it reaches a form and a degree where it incapacitates the person to such an extent that he can't be a reasonable, functioning member of society.

If you think for one moment about the causation of neurosis, you realize that a neurotic symptom represents a solution of a conflict between the individual's interests and the interests of the community. He is solving the conflict at his own expense so he can say, "I'm a good member of the community. I will not be aggressive. I will not gratify my instinctual desires. I will bottle them up within me."

From the point of view of prevention, this is important because what we are worried about is not so much that he is going to solve his conflict on his own person, but that he may solve his problems by manipulating others in his environment, and in this way affect many others. One mother with unsolved problems may distort the personality development of five or six children. One teacher or one foreman in a workshop who has unsolved problems in himself may distort the personality development and the emotional equilibrium of many, many other people who depend on him. This is what we at the Harvard School of Public Health call the "carrier" of emotional disorder, namely, the key person who is important to many other people and who, when they are in crisis, has the power through his relationship with them to tip them towards health or towards ill health. He has disordered relationships of such a nature that he acts destructively when other people get into a crisis situation.

If you can get hold of such a person, can you do something about him? And the answer is, "You can."

This whole area has opened up in the last few years. The techniques which have been developed have been called by some people "child-centered treatment of the mother" or "focused casework." Other people call it "segmental treatment." Call it what you will, it is a technique of interview treatment of a person whereby the worker focuses and delimits the area which is going to be the content of the discussion.

The worker decides what to let into the interview and what not to let into it. The focus is kept on a narrow segment in regard to the relationships of that key person with the other people—the child, or the other members of the family, or the workers in the factory. How this is done is a matter for study and research. All I wish to say here is that it can be done. And it can be done in certain cases very effectively and very quickly. I'm not talking about any kind of "battering

over" or any kind of "patting on the back" supportive treatment. I'm talking about a radical operation on attitudes and relationships.

The next form of direct intervention, the techniques of which still have to be perfected by the caseworker, is direct help to an individual in crisis. In this work, the social worker is operating as a direct, grassroots-level worker. She is present at the moment of crisis, and she uses her specific knowledge of the gamut of successful ways of adapting to this crisis and her general knowledge of the way in which people relate to problems and to other people, in order to bring her emotional support quite specifically into this play of forces and to tip the balance towards a new equilibrium in a healthy direction.

This is a very pointed intervention. In order to succeed we have to know quite a lot about the crisis and about techniques of handling people on such occasions. One important point to bear in mind is that if you press at the right time, you don't have to do it for very long and you don't have to do it very hard. At crisis time things boil up, and you have an opportunity you never had before and won't have afterwards.

The importance of this in community planning is that it gives us the opportunity for expending our skilled work in the most economical way possible at the focal point.

This leads me on to the indirect techniques which social workers may use during crisis. The social worker cannot be present herself during the crisis period of more than a fairly insignificant number of people. But we do know that there are professional workers, representatives of the community, who are normally present during crisis periods. Many of these crises—such as birth, marriage, death, etc.—are biosocial situations. They have been recognized in a special way in every culture system. Complicated customs, habits, traditions, and folklore have been developed in connection with these periods. What is the purpose of these? They appear to have been designed by the group as a whole to protect and support its individual members.

I think it is fairly certain that in a society which is fairly well integrated, where the culture is systematically sustained, there is a minimum of individual emotional breakdown. On the other hand, where a culture has become quite disorganized, for instance among immigrants or transplanted people who have been separated from home, and who, therefore, are just floating, from a cultural point of view, with no stability and no external framework or supportive scaffolding, the amount of individual emotional breakdown is phenomenal.

In a stable culture people who are the safeguarding, caretaking agents of the community, are normally present at the moment of crisis to help individuals on behalf of the community. The biggest problem of preventive psychiatry at the present time is the question of how to help these caretaking people act in an emotionally supportive way during these periods of crisis. The word "supportive" is rather a feeble word for something which can be so very pointed a weapon against disorder at such times. The important problem is—how can we help these caretaking people who are on the spot at the moment of crisis exert their pressure to tip the balance over to the side of emotional health?

We have done some research at the Harvard School of Public Health on this point and it is one of the main interests in the Community Mental Health program in Wellesley and in the newly established Mental Health Program in the Whittier Street Public Health Center. We call the techniques which we have been working out in order to solve this problem "mental health consultation." The mental health consultant, in this case a social worker, works with the grassroots, caretaking agents of the community with the idea of helping them

handle the crises of their clients in their prime. Such caretaking agents have included nurses, teachers, kindergarten teachers, clergymen, public health officers, general physicians, pediatricians, welfare workers, and community leaders.

Early in our work we made a discovery which seemed to us to be highly significant. We found that a caretaking person such as a teacher, who did a very efficient mental hygiene job with most of her pupils, failed completely to handle the problems of a small proportion of them. We found that a teacher with a class of 30 children would be doing a good job with 25, 26 or 27; but that in the cases in which she failed, she failed at the most important time, namely when those particular children were passing through crisis periods. She then brought her pressure down on the wrong side of the balance from the point of view of their mental health.

When we examined these cases, we found that the type of child with which any teacher failed, was related to certain problems with which the teacher had not been able to solve in herself. The teacher's problems might on investigation turn out to be primarily intra-psychic or they might be related to tensions within the school social system or between the school and the community, as for example, in tensions between parents and the teaching staff. Whatever the facts in any individual case, invariably these forces eventually narrowed down onto a disturbance in the relationship between the teacher and the child at that particular time and eventually focused on the child himself. At such moments of crisis the disequilibrium of the child was usually mirrored by a disequilibrium in the teacher. In other words, not only the child, but also the teacher was in a state of crisis. This was usually shown by her losing her professional distance from her pupil and becoming personally emotionally involved in his situation.

The picture presented by many of these teachers when they complained about the symptoms of one of their pupils resembled the familiar picture of the mother complaining of symptoms in her child. In the same way that such a mother when talking about her child can very easily be seen to be referring to her own problems, the story of the teacher in regard to her pupil's difficulties seems to have implications in her own situation.

Such a finding should not be in any way surprising to us. Both teacher and pupil are reacting in a dynamic way to the web of interpersonal forces of which they are both integral components. The particular child who is complained of at any time is not chosen by chance, but by virtue of the fact that his difficulties at that moment either stimulate or mirror in some way the here-and-now problem of that teacher in the current situation in that school.

There are, of course, children with some serious structural disturbance of personality which is relatively uninfluenced by the forces I am talking about. I do not refer to these, but to the much more common situation of a reactive behavior disorder in a child, which is the usual type for which teachers request advice and help. These are disturbing children but usually not particularly disturbed.

When the teacher is herself in a state of crisis, she is unable to perceive the child as a separate person or to be sensitive to his needs, and is therefore not able to help him in his trouble in any adequate way. Instead she reacts to the child's situation in terms of her own problems; and since she herself has been unable to solve these, what she does in regard to the child is usually not very effective.

In trying to work out methods for dealing with this kind of situation one rather obvious fact should be kept in mind. The mental health consultant cannot offer psychotherapy to the teacher; if he did so, she would probably kick him out, and quite rightly so. Her private problems are her own business, and

it is up to her how she wishes to handle them. She has not defined the consultation situation as one in which her own difficulties are legitimately to be discussed. The consultant has, however, been invited into that situation by the community and has been empowered to interest himself in, and to protect the mental health of, that particular segment of the child population. The community, moreover, implicitly places on the consultant the responsibility to have as wide a vision as possible in regard to the factors influencing the child's mental health. The teacher, in so far as she is a loyal community member, accepts the consultant in this role and empowers him to take whatever action necessary as long as it does not explicitly impinge upon her own personal, private rights. It is in this framework that the technique which we have called "mental health consultation" has been evolved.

I cannot say more than a few sentences about this technique here. A preliminary paper has appeared on this subject in the January 1954 issue of the *American Journal of Orthopsychiatry*. This is a paper I wrote jointly with Jona Rosenfeld, a social worker from Israel, on mental health consultation in an organization for immigrant children. Very briefly the technique consists of the consultant entering the child's environment and building up a relationship with the caretaking person, whom we call the consultee. Through the medium of this relationship, he picks up information on two levels; first, on the explicit level, the consultant gets a good deal of information about the details of the disturbance in this particular child, and the factors and forces impinging upon him from his environment. At the same time that this explicit information is gathered, the consultant is sensitive to the under-the-surface implications of the details and manner of telling the story in regard to the crisis situation of the consultee and the consultee institution.

These facts can only be picked up by implication and by "reading between the lines" because the consultee quite likely regards this situation as a professional one into which she should not explicitly intrude her private problems. But since these problems are pressing upon her and she is emotionally upset, she cannot help communicating something about them in a non-verbal way. She thinks she is just talking about the child; she is, however, at that moment in everything she does both in regard to the child and in her relationship with the consultant, talking about the things that are going on inside her. As long as this is only by implication and is not made explicit, the situation is felt by her to be quite safe. One essential point in the mental health consultation technique is that the consultant does not interfere with this defense structure of the consultee and never makes explicit the direct link between the problems of the child and the problems of the caretaking person. Should he do this, he immediately becomes involved in a psychotherapeutic situation which is always associated with problems of dealing with resistance. Such problems cannot be dealt with in the fluid situation of a consultation relationship.

The consultant has to pick up the implicit message which is being communicated without interfering with its non-verbal character. He must also learn to reply to this message in a similar, non-verbal way, and his implicit communication must be designed to support the emotional strength of the consultee and help tip her balance of forces towards a healthy equilibrium. In this communication, the consultant must accept the defenses of the consultee and not interpret or uncover in an explicit way things which the consultee does not wish at that moment to face.

The consultee doesn't say, for example, "I have unsolved problems in my relationship with my mother which are at the moment being stimulated because the headmistress of the school is a motherly person and I am at the moment

in conflict with her." This is much too difficult a problem for her to talk about with a comparative stranger, and it may even be so difficult that she is unwilling to think very clearly about it herself. Instead, she brings up a child for discussion with the consultant and she draws particular attention to the fact that this child is, at the moment, in conflict with his mother. This is very likely no artifact; the child may very well be having troubles with his mother.

But if all the consultant recognizes is that aspect, he's missing the main point of the consultation, namely, why does this consultee at this moment bring this child? The reason that she asked help for this child at this moment, is that at this moment this particular problem is important to her. She is disturbed by it; she is in crisis over it.

The way in which such a situation is handled, in this technique, is that the consultant discusses the problem by keeping it centered around the details of the child's difficulties. He discusses the child with a constant awareness of the implications of what he is saying to the consultee's problems. This results in a sort of three-cornered situation, where the consultee and the consultant are discussing the consultee's difficulties under the guise of talking about the child. One of the things which makes this technique so difficult is that the content in regard to the child must be meaningful at that level, and the consultant must constantly be killing "two birds with one stone."

I hope that I have given you some idea of the nature of this new technique; time does not allow me to say any more about it, but I hope that we soon will have worked it out sufficiently to be able to present it in a systematic way to other workers. It is complicated and difficult, but fascinating and potentially of tremendous import in this field. If it does not turn out to be what we want, then we've got to find something else that will do the same job. We've got to work out methods whereby a small number of highly trained people can work with the many caretaking agents of a community who are in so strategic a position during crisis periods to affect the mental health of so large a proportion of the community.

If we can succeed in working out some techniques of this nature and get ourselves trained in them, we will have developed for the first time a potent instrument whereby we may achieve some kind of approximation of community coverage.

Lastly, a few words about the social worker's responsibilities to the clinic team. I wish merely to underline two aspects of the social worker's role.

First, I believe that it is the job of the social worker, by virtue of her background and her long and arduous training in dealing with her own emotions in the professional setting, to spread among the other team members a willingness to admit and accept emotional disequilibrium not only in patients and clients, but also among other staff members and in themselves.

The second important contribution of the social worker to the team depends upon her knowledge of the supervisory process and of the importance of emotional support for the individual worker at moments of stress. By virtue of this knowledge, the social worker can help the team build up an atmosphere which will be supportive of its individual members, so that when they go out into the field where they are exposed to all kinds of emotional stresses, they go out not as individuals, but as emissaries of the group. Teachers in schools of social work must be very familiar with this problem. Social workers have discussed it and dealt with it more effectively than psychiatrists, and must have amassed a considerable body of knowledge which might be made available.

These are among the most valuable contributions which a social worker may make in a clinical team. The social workers and I have managed to make some

reasonable contribution along these lines in our Family Health Clinic at Harvard. We did not manage this entirely without difficulty both for ourselves and for our colleagues. People in allied professions may be very competent in their practice without having learned how to be comfortable about their own personal emotional involvement in a professional problem. It was not surprising that some of our colleagues were, in the beginning, rather ashamed to say, "Oh, I hate this patient. She really gets in my hair." Nowadays they are beginning to be able to say such things and to feel confident that they will not be rejected by the other people on the team, but on the contrary, supported in their efforts to disentangle their own emotional upset from the presenting professional problems. It is a source of great relief to an individual team member to know that the group will help him to avoid transferring onto his relationship with his client his own disequilibrium of the moment.

This certainly does not mean that I am suggesting that the social worker treat psychotherapeutically the problems of her fellow team members. It does, however, mean that she says to them, in effect, "You are entitled to have your emotional problems. We all have them, but they need not necessarily interfere with our work. As long as we stand together, we can have our personal problems and still do a good job. We cannot and need not deny that we too have emotions which may be disturbed, since this is after all one of the essential attributes of our common humanity."

In conclusion I would like to underline something which has been implicit in all I have tried to say to you this evening. The consideration of the role of the social worker in preventive psychiatry throws up many questions and very few definite answers: but some of the questions and some of the attempts at answers point to fascinating and challenging new vistas. For the first time we get glimpses of attainable practical goals, though it is clearer than ever before that much hard research work lies ahead. In this exciting work the social worker has an honorable and a difficult part.

THE MENTAL HYGIENE ROLE OF THE NURSE IN MATERNAL AND CHILD CARE*

By Gerald Caplan

An important trend in present-day mental hygiene is away from the concentration of effort on early diagnosis and treatment of individuals suffering from emotional disorder, and toward the goal of identifying and altering the sets of circumstances which might lead to such a disorder. Our attention has shifted from pathology in the patient to the pathological factors in the environment.

We recognize that the most significant area of a person's environment in relation to his mental health is the complexity of emotional interrelationships which focus on him. These relationships are most significant during his early formative years, but are important throughout his life.

In any community, certain individuals have roles which make them key people for the mental health of many others. If these individuals have disturbed relationships with their fellows, they may exert a pathogenic effect on their emotional life, and may be likened to "carriers" of mental ill health similar to the "carriers" of typhoid and other infectious diseases.

Preventive psychiatry is attempting today to identify such key people who are disturbed and have disturbing relationships, and to ameliorate their dis-

*Reprinted with permission from Nursing Outlook for January 1954.

torted attitudes in order to prevent their pathogenic effect in the community. It is also studying the circumstances which produce such disturbed relationships in order to prevent these people from becoming mental ill health "carriers".

This work is being undertaken in the hope that the further back the pathogenic process can be traced, the simpler will be the factors involved and the less costly will be their treatment.

In considering the circumstances which produce disturbed relationships and also the conditions under which these have their maximum pathogenic effect, the concept of emotional crisis has become important. Whatever their prevailing emotional relationships with their fellows, people are usually in a condition of emotional equilibrium. There is some stability in their mental life whether they are emotionally ill or healthy, whether they are carriers of mental health or of ill health. Under certain conditions, however, this balance of psychic forces is upset and for a period, often quite short, the person is in a state of emotional disequilibrium. At such times of crisis, a relatively small force acting for a short time may tip the balance either to one side or to the other, and once tipped over, a new stable equilibrium is obtained. Such a crisis may lead a key person to develop into a carrier of emotional ill health. During the brief period of disequilibrium, a person may be more vulnerable to the pathogenic effect of a "carrier." But it is precisely at such crisis periods that the mental hygienist may operate most profitably by lending his emotional strength to the healthy side of the balance of psychic forces and, by the expenditure of minimal energy, produce fundamental changes in the attitudes of people. The goal of mental hygiene, therefore, is to identify crisis periods among important people in the community, and to insure that they will emerge from these crises with healthy interpersonal relationships, so that they will not become carriers of mental ill health.

Among these key people are parents, kindergarten teachers, other teachers, army officers, foremen in industry, and similar persons in charge of others. Here we will discuss the mother, who has been studied more than any of the others. Although she comes into contact with a smaller number of susceptible individuals, her influence for good or ill on her young children is probably the most potent environmental factor in their emotional development.

In studying the circumstances which produce a disturbed mother-child relationship and turn the mother into a carrier of emotional ill health, we have learned that she goes through a period of increased susceptibility to crises which stretches from pregnancy through the lying-in period and into her child's first few years of life.

During pregnancy, the biological processes and their emotional impact stimulate the re-emergence of problems of her femininity and its association with her relationship to her own mother, which may have been only partially solved in the past. The general emotional crisis may also stir up any other personality weakness and lead to emotional disequilibrium. Problems for which solutions in the past were incomplete may be revived, giving opportunity now to find a better or a worse solution for them. Pregnancy, therefore, may lead to greater maturity and healthier relationships, or it may lead to the kind of pathogenic situation in which the expectant mother prepares to use the coming child as a partial solution for some of her problems. The danger is always present that she may relate to her child primarily on the basis of fulfilling her own need to solve those internal problems just mentioned. This type of relationship, likely to pervert the child's development, contrasts with a healthy mother-child relationship in which the mother reacts to her child primarily on the basis of her awareness of his needs and her attempt to satisfy them.

The emotional crises of pregnancy are produced mainly through stimulation by biological processes within the mother, but after the child is born and during his early years, similar crises may be produced because the mother is stimulated from without by her intimate association with him. As he passes through successive stages of instinctual development, this association stimulates the deepest layers of her personality structure, which were laid down when she was his age. Disequilibria similar to those occurring in pregnancy—with the same range of healthy or pathogenic outcomes—may be the result.

Mental hygiene activities during pregnancy and the postpartum period

These considerations led mental health workers to concentrate on programs of mental hygiene supervision for the pregnant woman and the mother of young children, and the following types of activity have been among those found useful.

Ego strengthening or general support.—This type of mental hygiene activity is nonspecific and is likely to be of some use in most cases. Regardless of the presence or absence of crises or of their types, the worker lends his emotional support to the patient, so that her balance of psychic forces is weighted down in the direction of health and maturity. This is accomplished by the worker actively expressing an attitude of human interest and an understanding of the mother as an individual with her own characteristics and idiosyncrasies, and by accepting her as she is.

This is a very concrete and practical kind of help, but it is hard to describe. The following examples may make it clearer.

A 31-year-old woman, after attending a sterility clinic for two years, was discharged from the clinic as a hopeless case, and she and her husband reconciled themselves with difficulty to a life of childlessness. The wife embarked on a professional career and they made elaborate plans to travel abroad in order to gain professional experience in different countries.

In the midst of these plans, the wife suddenly became pregnant and much to her own and her husband's surprise she reacted violently against it. Though she attended the prenatal clinic regularly and cooperated fully with her doctor, she was quite outspoken in her rejection of the pregnancy, and continued working until the last possible moment. She ascribed her resentment to the unexpectedness of this interruption of her carefully laid plans, saying, "Previously when I did all I could to have a baby, I couldn't become pregnant and now when I have given it up and got going on something else, this comes along!"

The mental health workers were very interested in the underlying psychological mechanisms, but they made no active attempt to uncover them. Instead, they built up a warm relationship with the woman and encouraged her to verbalize very freely her complaints against the unpredictability of her fate. Far from urging her to accept her lot with gratitude, they made their sympathy clear to her, and let her know that they understood her negative feelings, and that they accepted and respected her just as much as they did patients who were happy with their pregnancies. This support became all the more meaningful to her as month followed weary month, and her complaints and rebellion continued unabated. She was repeatedly reassured that this free expression of her hostility to the pregnancy cast no reflection on her capacities as a potential mother and she was supported in her hopes that when the baby should be born, her original positive attitude to motherhood would return.

Her negativism did not disappear until she went into labor. A day later when she put her son to her breast for the first time, she felt a sudden wave

of motherliness sweep over her, and thereafter she behaved like any average mother who loves her child.

A nineteen-year-old girl had suffered since childhood from all kinds of anxieties and fears. When she became pregnant, these were intensified and in addition to her old fears of the dark, burglars, heart trouble, or dropping dead, she was terrified that her baby would die, would be born mentally defective, or be a monster or blind or crippled.

Whenever she came to the prenatal clinic, and during frequent home visits by the nurse, she was allowed to talk freely about her fears and she was listened to with patience and sympathy.

She was not reassured directly but her anxiety usually lessened when she became aware that the worker, listening carefully to her horror stories, was in no way upset by them. She was much strengthened when she found that she wasn't laughed at, or told to pull herself together, but that she was accepted as she was—a weak and nervous girl struggling hard to cope with problems that most other people hardly bother about. Any signs of strength were noted and praised and the positive feelings she had about her husband and her pregnancy were recognized and appreciated. She was surprised to find that the workers continued to respect her despite all her nervousness, which she had previously felt to be in some way morally reprehensible, and her own self respect was increased by this.

She bore her labor with what was for her great bravery but almost collapsed during the lying-in period when she was faced with the responsibility of caring for her baby. She was encouraged not to breast feed and she was allowed to move very slowly in taking over the care of the child. During her first few weeks at home, the nurse made frequent visits and answered innumerable phone calls. She allowed the mother to be childishly dependent on her and accepted her very slow development toward ordinary maternal responsibility.

Little by little, this mother began to realize what she meant to her baby, who was so much more helpless than she, and whose satisfactory development soon began to bear witness to her maternal devotion. After the third or fourth month, the patient's fears lessened considerably and with her increasing pride in her motherhood, a characteristic maturing process became evident in her total personality.

It is hard in these and other cases to evaluate the importance of these techniques. A meaningful emotional relationship between the mother and an accepting non-judging worker certainly helps to strengthen the ego-integrative forces in the mother's personality. Perhaps the chief significance of such a relationship lies in its insurance value—in case of a crisis, the mother can immediately borrow strength from the worker to whom she has become attached.

Mobilizing environmental sources of love and support.—The pregnant woman needs extra love just as much as she needs extra vitamins and protein. This is especially so in the last few months of pregnancy and during the nursing period. During pregnancy she often becomes introverted and passively dependent. The more she is able to accept this state, and the more love and solicitude she gets from the people around her, the more maternal she can be toward her child. Professional workers cannot give her the love she needs, but they can mobilize the members of her family, and especially her husband, to do so. In our culture, husbands and other relatives are often afraid of "spoiling" the expectant mother and special efforts are needed to counteract this attitude.

A warm and sensitive young girl, married to a rather cold, intellectual, and shut-in man, showed many signs of insecurity throughout pregnancy. She sometimes talked of her longing to see her mother, to whom she was much attached,

but who lived 30 miles away. Her husband was away at his job all day and most of the evening, so she had bought a pet dog to comfort her in her loneliness. The husband was told of his wife's increasing demands for signs of affection and said that he feared she was getting soft and childish. In a couple of short discussions, he was helped to ventilate his anxiety that she would become an emotional burden on him. He was then urged to spend as much time as possible at home and was reassured that her regressive passivity and increased demands for love were quite normal manifestations of pregnancy. He was advised to make special efforts to demonstrate his love as concretely as possible, both by personal attentions and by helping with housework. He was also supported in a plan to buy a small secondhand car so that his wife could visit her mother. His relations with his mother-in-law were cool, but when he understood the importance of providing his wife with as much love and affection as possible, he readily agreed to invite his mother-in-law to stay with them during the last week of pregnancy and the first few weeks after his wife returned with the baby.

The young mother's response to these simple measures was gratifying, and she made a surprisingly smooth adjustment to the early stages of nursing and caring for her baby.

Anticipatory guidance.—This technique has been much described during recent years and will, therefore, receive only brief mention here. It is a valuable method of mobilizing the patient's strength beforehand so that she is able to meet a crisis situation more constructively. She is told in detail what to expect, and by imagining in advance what it might feel like, she is able to lower her anxiety level and to develop a readiness for a healthy reaction. It is worth stressing that the technique works best when the future events are described in greatest detail and when the patient is given a full opportunity to discuss her feelings and particularly her anxieties beforehand.

In order to use this method, the worker must know the usual physical and emotional changes of pregnancy, labor, and child development, and he must be able to formulate his predictions reassuringly and yet without slurring over possible sources of difficulty. Examples of topics which can usefully be discussed with every pregnant woman include the sudden unexplainable mood changes, the irritability and emotional lability, and the passivity which are so frequent in pregnancy. Possible changes in feelings about sex activity should usually be discussed as early as possible with both husband and wife. Fears and superstitions about maternal impressions, difficult labor, and congenital abnormalities of various types are rendered less troublesome if these worries have been mentioned earlier by the worker as being a very significant inheritance from past ages.

Educational preparation of the expectant woman for labor has been advocated principally by the devotees of natural childbirth. It is certainly not necessary to subscribe to this doctrine in order to realize the importance of this technique. There is little doubt that a woman who has been told exactly what to expect will have a smoother and less traumatic experience in labor than someone who has no idea of what is coming next and is therefore a prey to her morbid imagination.

Similarly a few short discussions ahead of time on breast feeding will pay excellent dividends, apart from helping an ambivalent woman to come to a clear decision beforehand, whether or not to nurse her baby. One mother felt no real love for her baby until he was three weeks old. Up to that time, she was interested in him and felt sympathetic and protective, but no more so than toward any other baby. She was not at all disturbed by this, and made a satis-

factory adjustment to breast feeding because she had been explicitly warned that this lack of maternal feeling would probably occur as a temporary phenomenon. This is an extreme case, but delays of two to five days before the mother feels fully maternal are not at all unusual nor are they unnatural.

Help in specific crises.—Intervention directed toward insuring a healthy outcome to an emotional crisis must operate at the time of the acute disequilibrium in order to achieve a maximum effect. The same effort applied after the acute phase is over will have less chance of changing the balance. For this reason it is important to learn to recognize the crises of pregnancy and the post-partum period and, if possible, to be alert to their prodromal signs so that they can be predicted and prepared for.

This is an area in which our knowledge is still very scanty, but the following examples serve to illustrate what is involved.

A woman who had been adapting fairly well to her pregnancy suddenly became tense and anxious in her seventh month. She complained of mental confusion and ineffectiveness. She gave a history of a disturbed relationship with her mother, who had suffered a psychotic breakdown when the patient was a young girl and had been in a mental hospital for a couple of years. In an interview with the psychiatrist, the patient described with much emotion how upset she had been when her mother was taken away, and also how she had had to act as mother to the rest of the family, and even to her mother for years after her discharge from the hospital. In connection with her own present upset, she said that she was having a desired pregnancy and had felt fine until a week previously, when she had begun to feel passive and useless. Despite all her efforts, she could not shake off this apathy and she was now tense and sleepless. She said she was happily married but was completely frigid and even had some dyspareunia.

The psychiatrist pointed out to her that her introversion and passivity were a natural reaction of her present stage of pregnancy, but that apparently she had become very frightened because this sudden change in her feelings reminded her of her mother, who had always been a passive and ineffectual creature. She then broke into violent weeping and said that she was afraid she was going mad like her mother. She was shown how she had made an irrational link between her passivity and her mother's illness and she was urged to try to let nature have its way with her and to try to enjoy the passivity, instead of fighting it, as a positive contribution to her pregnancy.

She was tremendously relieved and very grateful for this help. During the rest of the pregnancy she was seen regularly for short interviews in which the same advice was repeated and she became quite relaxed. She had an easy labor and made a fairly good adjustment to breast feeding, but she required continued support during the first few months of motherhood to relieve her anxiety that she would fail as a mother. Interestingly enough, six months after the delivery, she reported that she was no longer frigid and that she was planning another baby.

This girl had a deep disturbance of personality, involving conflicts relating to her femininity based on traumatic experiences with her mother. Orthodox psychotherapeutic help would probably have been difficult and certainly a very lengthy affair. When the biological changes of pregnancy precipitated her into a state of passivity, it upset her previous emotional equilibrium, in which she had defended herself against identifying with the mother's femininity by always being active and dominant. At this strategic moment, it was possible to help her to realize that passivity and femininity were not dangerous, and that she could be a woman and a mother without suffering the fate of her own mother.

This help—as is possible in many cases—did not entail the lengthy process of giving her insight into the origin of her difficulties.

Another woman, toward the end of her second pregnancy, began to express worries lest she give birth to an ugly girl. Her first child was a girl and was very pretty. She feared that the coming baby could not be as nice and would be bound to have a hard time. She herself had been a tomboy and her mother had favored her older sister who was pretty and feminine. Earlier in the pregnancy she had related this information with little show of emotion but as delivery date approached, she remembered with great vividness her childhood jealousy of her sister and her own feelings of inferiority and insecurity in regard to her mother's affection. She was encouraged to talk freely about those old problems and she was shown quite directly that she was preparing to identify her new baby with herself as the younger of two girls, and was worried lest she reject it in the same way she imagined her mother had rejected her. This kind of encouragement relieved much of her anxiety but it is impossible to say how effective the intervention was because she gave birth to a boy.

This case is very interesting because it shows the train of events leading to the use of a child to work out unsolved conflicts of the mother. It also shows how buried problems come to the surface during pregnancy, and hints at the ease with which they can be handled.

A primipara had a smooth and normal pregnancy but had a long and difficult labor and the baby suffered a left-side facial paresis from forceps. The mother had a bladder injury and had to stay in bed with an indwelling catheter. For administrative reasons, the baby was cared for in a nursery on a different floor of the hospital from the mother. Because the mother was unable to see it for the first three days, she refused to believe that the baby had only a mild injury. Her tension was relieved when she was given a true picture of the diagnosis and was told that she was entitled to be depressed and was encouraged not to try to put on a bold face. She was also given supervision and supportive help during breast feeding. During this contact she confessed that she had been blaming herself for the difficult labor and the baby's injury, feeling that she had not carried out all the instructions given her in the prenatal clinic, particularly in regard to stopping sexual intercourse at the thirty-fourth week. Her guilt in relation to this was relieved.

This is a typical example of the danger to the mother-child relationship of a bad start, and the way in which the reality of a birth injury rapidly becomes involved in guilt fantasies based on past conflicts.

A young music student was seen in the fourth month of her pregnancy. She seemed strangely anxious about the well-being of the fetus and spent a long time discussing the signs of quickening. She admitted that the pregnancy had been unplanned and unwanted. A month later she was still asking for reassurance that the fetus was alive and healthy, which caused the obstetrician to suspect that she had done something to try to terminate the pregnancy. He told her that young girls who are upset at becoming pregnant sometimes try to interfere with the course of nature, and asked her outright whether she had attempted abortion. With much emotion, she confessed that she had done so but that she had told nobody about it—not even her husband, who was a theology student and felt that abortion was a terrible sin. She came from a religious family and they, too, would be upset if they found out what she had done. Now she felt terribly guilty and was sure that she had injured the baby. She felt she might have killed it, or least if it lived to be born, it would be a monster of some kind. The obstetrician made no attempt to hide

the fact that he felt she had done wrong, but by his tone of voice and by his continued interest he made her realize that her feelings of guilt were very much exaggerated. Opening up the subject and giving her the chance to share her secret offered her tremendous relief and when he felt that he had lessened her guilt feeling sufficiently, he then reassured her in regard to her anxieties that she had injured the baby. The obstetrician's simple but timely intervention saved this girl not only from the further torture of pathological guilt and anxiety, but from a probable disorder of her relationship with the child.

We have come to recognize that a failed attempt at abortion is a potent cause of a peculiarly pathogenic disorder of mother-child relationship. The mother typically shows great guilt in her handling of the child, feeling that she had previously attempted to murder him. She is tremendously anxious about his health, fearing that she must have injured him in some way, and by coddling and overprotection she manages to make him into a weakling, whom she takes from doctor to doctor for all kinds of treatments. She feels that this sickly creature who makes such demands on her time is the punishment for her crime. Often she regards him as the visible sign of her own badness and behaves quite cruelly to him, symbolically castigating her own sin in him.

Such children often appear in child guidance clinics with distorted personality structures. At this stage, it is hard to do anything for them and it is no consolation to the psychiatrist to trace the history of the disturbed mother-child relationship back to its origin in the traumatic incident of early pregnancy and to realize that a few sessions of simple treatment at that time would probably have prevented the subsequent sad development.

The specific role of the nurse

Has the nurse a specialized function in this field of mental hygiene? She is a general practitioner among the many specialists who operate in maternal and child care—obstetricians, pediatricians, nutritionists, psychiatrists, psychologists, and social workers; she must know something of each of these specialties, and yet she is not competent to operate independently in any of them. She knows this and so does the patient, which is bound to make the nurse feel rather insecure. The competent nurse must know the boundaries and limitations of her work, but this insecurity may lead to the defense of denying her limitations, and trying to operate in the area of one of the specialists. Has she then no specialized function of her own? I feel that the answer to this question is very definitely in the affirmative.

The nurse's specialized function arises from her very special position in relation to her patient, and this is a role which is not open to any of the other specialists, except under atypical conditions.

The chief characteristic of this position is closeness.

Closeness in space.—The nurse goes into the patient's home, and in the hospital she remains at her bedside. She penetrates physically into the patient's environment.

Closeness in time.—The nurse's contact with the patient can be constant and continuous. She can make home visits throughout pregnancy; she is constantly present during labor and the lying-in period and when the mother returns home she can follow her there. It is not too difficult administratively to keep the number of nurses dealing with one patient at a minimum, and thus provide a unitary link right through the period under discussion. Apart from the importance of this in building up a supportive emotional relationship, its chief

significance is that the nurse may often be actually present throughout a crisis situation.

Sociological closeness.—The traditional role of the nurse makes the patient regard her as being on the same status level as herself. In the professional relationship the patient feels that the other specialists are high above her in status; she regards them as parent figures, but on this scale she considers the nurse a sibling figure. This means that communication is free and easy and involves little tension. She feels that the nurse speaks her language. There is no need to put on a show in front of her and she is not afraid to ask questions. In many countries this sibling role of the nurse is symbolized by calling her "sister." She is traditionally not just an ordinary sister, but a specially wise sister—an older sister with experience and one who is interested in helping.

Psychological closeness.—Linked with the sociological closeness, which is based on the patient's perception of the nurse, is the fact that the nurse maintains less psychological distance than other professionals in treating her patients. She involves herself more freely, and uses herself more directly in a more unsophisticated and less rigid way, and with the use of fewer formalized psychological techniques. This human closeness is reciprocated by the patients, who show their feeling of freedom and ease by rapidly building up a trusting relationship.

I feel that this closeness is unique among the professional workers who are in contact with the mother and young child. The fundamental role of the wise sister, who is on the spot in time of trouble, gives the possibility of a unique and specialized function to the nurse. It is an important heritage, which must be jealously guarded, for if it is lost, the specialized mental hygiene functions of the nurse will be lost with it.

Mental hygiene functions of the nurse

Case finding.—The nurse has the broadest contact with the mother and her human and physical environment. She can make her observations and collect her information when the people concerned are not on their guard and putting on a show. Moreover, she is frequently present when the members of the family are together, so that she can actually observe their interactional behavior. This may throw a quicker and truer light on their interpersonal relations than hours of history taking. This allows the nurse to specialize in identifying crisis situations, and in recognizing environmental circumstances which are hazardous to the interpersonal relationships of the patient and her family.

Initiation of motivation.—Having recognized a situation which is a mental health hazard, the nurse has an essential role in arousing the individual's motivation to seek the right professional help. In this work, since we are operating in a field in which symptoms often do not exist as a stimulus to seek help, and one in which the family members usually do not feel a need to involve themselves, the problem of motivation, which in the therapeutic setting is relatively simple, here becomes complicated and difficult. It is a problem which in certain cases may make the biggest demands on the skills of the psychiatrist, but the nurse must make the first move because it is her link with the mother or the relative which makes the initial interview possible.

Interpretation of the patient to the specialists.—Routing the patient to the appropriate specialist is often the nurse's function, and is managed efficiently in most clinical settings. What is less well managed usually is the interpretation of the patient and her environment to the specialist sitting in his office. The

nurse moves freely between the two worlds of patient and specialist. In each she should be regarded as an equal, and it should be her function to act as an emotional and intellectual bridge between them. Too often the wealth of information she has collected about a case remains locked inside her, and is not passed on to the other specialists. There are many reasons for this, but one thing is certain, and that is that both the nurse and the other professional workers ought to try to work out a more efficient method of insuring this essential communication.

Interpretation of the specialists to the patient.—It is the nurse's job not only to translate the words of the specialists into the patient's language, but also to unify the prescriptions of the different specialists and help the patient accept them as part of a coherent framework. It is interesting that at the present time she has much less difficulty dealing with interpretation in this than in the reverse direction.

Emotional support.—The special way in which the nurse gives emotional support has already been stressed—she gives assistance as a "wise sister." Because of this the patient can accept her help without loss of independence or self-esteem and, therefore, usually shows less resistance. The support is available on the spot, in time of crisis, and can be of the general nonspecific type previously described.

The nurse can stimulate and build up the supportive relationship by giving advice and practical demonstrations of service to the pregnant woman for herself and the infant. Help in preparing the layette, bathing the baby, making the formula, and supervising breast feeding brings the nurse and the patient into a close collaborative relationship. These procedures should be regarded not only as opportunities for imparting knowledge, but, perhaps more importantly, as occasions for fostering and supporting the ego strength of the mother.

Teaching.—Adding to the mother's store of intellectual knowledge increases her ego strength, and this is regarded as a principal mental hygiene function of the nurse. The nurse as a health educator, however, has a difficult job to perform if she wishes to avoid endangering her fundamental wise sister role. The risk is that she will adopt a teacher role in relation to her patient, and if she does so, her sociological closeness is immediately destroyed. A teacher is typically conceived of by people as having a higher status position than themselves; the nurse who becomes teacher becomes a parent instead of a sister.

To impart knowledge without assuming teacher status is a technique that has still to be worked out, but it is possible. It is important that the nurse should have a systematic schedule of information to convey, but she should avoid systematic teaching sessions and she should aim at informal teaching techniques—if possible, in group situations, where mothers have an opportunity to teach each other. It is important to stop using the term Mothers' Classes for such groups, and in leading them, the nurse should use democratic methods. She should not set herself up as an expert but rather as someone who is conveying what the experts say. Above all, she should try and help the mothers clarify their own thinking and learn actively rather than receive her teaching passively.

Mobilizing the environment.—This mental hygiene function, which has been described elsewhere in this material, is essentially the province of the nurse.

Problems and difficulties

My contention that the nurse's closeness to her patient is the fundamental basis for her unique mental hygiene role does not imply that I am opposed to the present efforts of nurses in this country to raise their professional status

to the level of the other specialists in the field. On the contrary, I feel that the difficulties inherent in the interpretation of the patient's needs to the specialists is largely due to their perception of the nurse as a worker of lower status whose reports are not likely to be very valuable. Increasing professionalization, as a result of better preparation, would improve this situation of interdisciplinary collaboration.

In order to act as the bridge and the mediator between the patient and the specialists, the nurse must be regarded by each as being at the same status level as their own group. She therefore has the difficult task of being "all things to all men."

The danger at present is that in her efforts to achieve increasing professionalization, she may strive to become a specialist just like all the other specialists, and she may feel that to do so means that she should give up her sibling role with her patients. I can envisage that the idea of growing from a sibling role to a parent role may be a seductive one, but I would warn against "selling your birthright for a mess of pottage."

I would emphasize that the concept of the nurse as a wise sister involves a great challenge to nursing education. It implies a higher standard of professional education in order to merit the description "wise," and this education must be very carefully planned and executed so that the nurse may retain or develop the necessary emotional qualities to allow her to be a sister to her patient. This whole problem merits the most careful consideration by those who shape the policy of the nursing profession.

Techniques of interviewing and handling patients appropriate for the nurse's use need to be studied and developed. At present, most of the techniques in this field have been developed for other disciplines and, unchanged, are not transferable without endangering the nurse's status position. There is also a need to work out how such techniques can be used without increasing the psychological distance between nurse and patient.

A technique which is immediately available for the use of nurses is that of reducing a patient's superficial guilt. An example was given in the case of the expectant woman who had failed in her attempts to terminate her pregnancy. The nurse should be taught how to identify this type of guilt, since it is a potent factor in perverting interpersonal relationships, and she should learn how to deal with the problem as a routine part of her work.

The thinking of the last few years has brought us to the threshold of a great new field in mental health practice, but our basic knowledge in regard to details of the common emotional crises of pregnancy and infancy is still very scanty. We know even less about the special circumstances which are likely to produce mental health hazards. It is surprising how little scientific research has been undertaken to describe the dynamic development of the emotional life of the ordinary pregnant woman.

In order to build up efficient mental health nursing programs we will have to investigate this area and learn the facts. For maximum productiveness, such research should be carried out on a collaborative team basis within a framework of all the disciplines, including nursing. This type of multidisciplinary research is difficult to organize and is very costly, but we have reached a stage where it must be regarded as essential.

Examples of the situations which are likely to lead to mental health hazards and should therefore have research priority are: prematurity, Rh negative mothers, illegitimacy, multiple births, failed attempts at abortion, severe illness or death of a near relative during pregnancy, birth trauma in the child, and

similar situations. The aim of this research would be to develop specific categories of identifiable circumstances which lead to mental health hazards, and to provide the nurse with indications for specific action in each case.

The mental hygiene work that is based on the nurse's closeness to her patient inevitably involves the nurse herself in emotional problems. The danger is that she will find herself in crisis situations because her own problems are stimulated by those of her patients. This closeness makes her vulnerable in this respect. The likelihood that her patient's problems may set up internal disequilibrium in the nurse is especially great in this field of maternal and child care, because of its significance to every woman, and especially to a woman in the child-bearing years.

One unfortunate result of such a process might be that the nurse might try to work out her own problems through her patients. This might show itself by her usurping the mother's role and becoming possessive of the baby, or by being possessive of the case in relation to the other workers in the field. Another way in which the nurse might attempt to deal with her emotional upset would be by withdrawing from the possibility of involving herself with her patients, either by becoming insensitive to their problems or by increasing her psychological or sociological distance.

It must be emphasized that such emotional upsets are likely to occur in nurses of stable personality if they are doing an efficient mental hygiene job, and must be regarded as a routine occupational hazard.

If this analysis is correct, and our experience indicates that it is, mental hygiene activity by nurses should be planned to include specific safeguards in order to protect the nurse and to minimize her working difficulties.

The best safeguard is an efficient system of technical supervision along the lines which have been worked out in casework and psychotherapy. This is a relatively new idea in nursing; proper methods and organizational framework have still to be developed.

The general nursing supervisor certainly has a part to play. By the atmosphere she creates in her unit, and by the manner in which she conducts herself in relation to the nurses, she sets the tone for their relationship with their patients. She is able to provide a background of nonspecific emotional support which she expresses in her attitude of trust in the capacities of the nurses, her respect for their individuality, and her tolerance for their emotional difficulties. She can also be of limited help in some crisis situations, but her hands are bound by the demands of her leadership role, which forces her to keep the relationship between the nurses and herself on a strictly reality basis. If she permits herself to become involved to any extent in their fantasy life, she will usually experience difficulty in carrying out her tasks as their administrative superior within the agency's hierarchy.

For help in times of emotional crisis, the nurses need someone with whom they can have a freer emotional relationship than is possible with their supervisor—someone outside the administrative hierarchy, with whom they can share their secret emotional reactions without fear of it one day counting against them on the job. This person can allow herself to be involved in their fantasy life since she has no commitments which conflict with this. She can, by her permissiveness, allow the development of the special kind of relationship which can be used to help the nurses achieve a more mature solution of their problems in relation to their work.

I wish to emphasize that this outside supervisor—the mental hygiene consultant—does not carry on psychotherapy with the nurses. She restricts her

intervention to helping them overcome the emotional obstacles which prevent them from operating to their maximum efficiency in the case which is brought to consultation. Consultation technique aims at excluding discussion of the private life of the nurse and deals with her problems by helping her find a solution to the patient's difficulties. The benefit to the nurse is obtained vicariously when she is helped to overcome her own troubles, once removed, in her patient.

The mental hygiene consultant nurse is a new arrival and she has much hard work ahead of her in developing her techniques and in establishing her position in the organizational framework of the nursing profession. That she has arrived is a welcome sign of the increasing recognition of some of the important problems I have tried to put before you.



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